
# Community Consumer Submission 3 (CCS 3) Extract Specifications Version7.5

**Issued: March 4, 2019**
**Effective Date: July 1, 2019**

# Revision History

| Date | Version | Author | Description |
|---|---|---|---|
| 7/1/2009 | 1.0 | P. Gilding | Original for Fiscal Year (FY) 2010 |
| 7/1/2013 | 7.1 | P. Gilding | Update for FY 2014 |
| 1/1/2014 | 7.1 Rev1 | P. Gilding | Revision for Mid-Year Release, FY 2015 |
| 1/1/2014 | 7.2 | P. Gilding | Consolidated for FY 2015 |
| 1/1/2015 | 7.3 | P. Gilding | First update for FY 2016 |
| 7/1/2015 | 7.3.1 | P. Gilding | Second update for FY 2016 |
| 7/1/2016 | 7.3.2 | P Gilding | First update for FY 2017 |
| 7/1/2017 | 7.3.3 | P. Gilding | Update for FY 2018 |
| 7/1/2018 | 7.4 | P. Gilding | First Update for FY 2018 |
| 10/30/2018 | 7.4.1 | P. Gilding | Second Update for FY 2018 |
| 3/4/2019 | 7.5 | S. A. Elmore, PhD | Update for FY 2020 implementation |

# Community Consumer Submission 3 Extract Specifications: Version 7.5

## Table of Contents

# Community Consumer Submission 3 Extract Specifications: Version 7.5

## Purpose and Scope of CCS 3

### Purpose

The Department of Behavioral Health and Developmental Services (Department) developed these CCS 3 Extract Specifications in collaboration with the Data Management Committee (DMC) of the Virginia Association of Community Services Boards (VACSB). The Department, in partnership with community services boards and the behavioral health authority (CSBs), uses the Community Consumer Submission (CCS) to comply with federal and state reporting requirements, including those in the federal substance abuse Treatment Episode Data Set (TEDS) and federal mental health (MH) and substance abuse block grants (MHBG/SABG); to submit data to state funding sources, including the General Assembly and Department of Planning and Budget; and to produce data about the performance of the public mental health, developmental, and substance use disorder (SUD) services system. State and federal policymakers and decision-makers and many others use this CCS data. The CCS provides data for comparisons of and trends in the numbers and characteristics of individuals receiving direct and contracted mental health, developmental, and substance use disorder services from CSBs. Version 7.5 incorporates all revisions made to the Specifications since Version 7, issued in 2009, and shows changes from Version 7.4.1 in red text.

This document provides CCS 3 extract specifications to CSB information technology (IT) staff and vendors for reporting data about individuals and services through the Department's CCS process. The principal audiences for this document are Department and CSB staff and CSB IT vendors involved with collecting, reporting, and using data about individuals receiving services and the direct or contracted services they receive from CSBs. CSB staff and IT vendors responsible for implementing CCS 3 should review and must adhere to these Extract Specifications and the current CCS 3 Business Rules, incorporated by reference into these Specifications and distributed with the current CCS 3 application release. These rules establish acceptable parameters and validation criteria for CCS 3 data elements and describe error-checking routines and operations. CSB IT staff and vendors also should review and must adhere to applicable parts of the current core services taxonomy, such as service and service unit definitions. The extract specifications are incorporated into and made a part of the current community services performance contract by reference.

Core Services Taxonomy 7.2 and the FY 2010 Community Services Performance Contract eliminated requirements for reporting data in Community Automated Reporting System (CARS) reports about the numbers of individuals who received services and units of service they received because this data is now reported through the CCS. Eliminating redundant reporting requirements reduced data errors and improved the completeness and accuracy of CCS data.

### Scope

Through CCS 3 Version 7.5, the Department collects 84 required data elements from CSBs about services and individuals in a secure single submission to the Department. CCS software does not require any additional data entry. Instead, CSBs extract data from their local information systems or electronic health records (EHRs) by exporting the data into the CCS application for the creation and transmission of required files.

The CCS is a compilation of demographic, clinical, and descriptive data about individuals with mental illnesses, substance use disorders, developmental disabilities, or co-occurring disorders and data about the mental health, developmental, substance use disorder, emergency, and ancillary services they receive. In this document, mental illnesses, substance use disorders, and developmental disabilities refer to conditions that individuals experience, while mental health,

substance use disorder, and developmental refer respectively to the services that address those conditions. For the CCS to produce valid data, all CSBs must submit complete and accurate data using the same formats and definitions. This document provides definitions of the information needed to produce the standard data files and the extract specifications that are required for CSBs to report individual level data through the CCS. This document also describes the process of submitting CCS files to the Department.

## Definitions and Guidance for CCS Reporting

The core services taxonomy is used, per State Board Policy 1021 (SYS) 87-9, to classify, describe, and measure services delivered by all CSBs directly or through contracts with other providers. The taxonomy defines many of the terms used in these Specifications, definitions in the current taxonomy, available at http://www.dbhds.virginia.gov under Office of Management Services

## Individual Receiving Services

Section 37.2-100 of the Code of Virginia defines an individual receiving service(s) or individual as a current direct recipient of public or private mental health, developmental, or substance use disorder treatment, rehabilitation, or habilitation services. This definition includes the terms "consumer," "patient," "resident," "recipient," or "client" used in previous statutes, regulations, policies, and other documents. This version of the CCS 3 Extract Specifications uses individual or individual receiving services, unless the context requires the use of consumer (*e.g.*, the Community Consumer Submission). CCS 3 does not collect or report information about individuals receiving substance use disorder prevention or Part C infant and toddler early intervention services; other reporting mechanisms collect this information.

Information about all individuals receiving any direct or contracted CSB services defined in the core services taxonomy, except for substance use disorder prevention services, Mental Health First Aid and suicide prevention services, or infant and toddler early intervention (Part C) services, must be reported in the CCS. Since the CARS no longer reports data about individuals receiving services, there will be no other source for this data except the CCS. CSB information system or EHR extracts that generate data for the Department's CCS 3 extract must include information in Consumer.txt files only about individuals who have an open record or have been admitted to a program area and have received a valid service or have been discharged from a program area with or without receiving a service during the fiscal year (active individuals). CSBs must not include other individuals in Consumer.txt files.

## Z-Consumer:

An individual receiving service(s) is identified in the CCS by a hashed social security number (SSN) and a consumer identification number (ConsumerId). However, when a specific individual is not identified as receiving a service, a z-consumer code is used in the Service.txt file. The letter z (lower or upper case) in the first position of the ConsumerId field (data element 7) identifies this z-consumer code. Any value in that field that begins with the letter Z will be considered an unidentified individual, regardless of the characters that follow it. CSBs must not use a z-consumer code to report services received by groups of individuals; a separate Service.txt record must be submitted for each individual receiving the service. The core services taxonomy contains more detailed information about service hours reported for z-consumers.

## Program Area

The core services taxonomy defines program area as the general classification of service activities for one of the following defined conditions: mental illnesses, developmental disabilities, or substance use disorders. The three program areas in the public services system are mental health, developmental, and substance use disorder services, ProgramAreaId codes 100, 200, and 300. CCS 3 also includes the 400 code as a pseudo ProgramAreaId to identify emergency or ancillary services (services outside of a program area). CSBs must use code 400 only in the Service.txt file, not in the TypeOfCare.txt file. CSBs must not admit or discharge individuals to or from the 400 code.

## Service Codes and Units

The core services taxonomy defines services. CCS 3 identifies a service by a program area or pseudo program area code and a core services category or subcategory code (service code) with a corresponding unit of measure. This includes all services received by individuals from the CSB directly and from CSB contractors. All contracted services included in performance contracts and CARS reports must be included in CCS 3 service files. CCS 3 reports actual service delivery; it does not collect or report estimated units of services. The taxonomy identifies these service codes and defines their corresponding units; refer to it for complete definitions of service units. The units (data element 10) field captures and reports the number of units of services received by individuals. CCS 3 reports the following types of service units in this field: service hours, bed days, day support service hours, and days of service. Appendix F lists valid program area and service codes.

## Consumer-Run Services

Consumer-Run Services (730) are not traditional clinical or treatment services, and the nature and context of these programs emphasize individual empowerment and provide support in an informal setting. See the definition for these services in the current taxonomy. No Service.txt records are submitted for this service, and no Consumer.txt records are submitted for individuals who receive only consumer-run services. CSBs providing this service gather and report information about it and the individuals receiving it separately in the CARS management report, rather than in CCS.

## Service Hours

A service hour is a continuous period measured in fractions or multiples of an hour during which an individual or a family member, authorized representative, care giver, health care provider, or significant other through in-person or electronic (audio and video or telephonic) contact on behalf of the individual receiving services or a group of individuals participates in or benefits from the receipt of services. This also includes significant electronic contact with individuals receiving services and activities that are reimbursable by third party payers. Service hours measure the amounts of services received by or on behalf of individuals or groups of individuals. Service hours are reported in the CCS Service file only for the following core services:

- Emergency services,
- Motivational treatment services,
- Consumer monitoring services,
- Assessment and evaluation services,
- Early intervention services,
- Outpatient services,
- Medical services,
- Medication assisted treatment,
- Assertive community treatment,
- Case management services,
- Individual supported employment,
- Supportive residential services, and
- Mental health or developmental prevention services.

- Intensive outpatient services,

CSBs must not report service hours in the CCS for any other services. CSBs report substance use disorder prevention services and Mental Health First Aid and suicide prevention service hours through the Department's contracted prevention services data system and must not include them in the CCS. CSBs collect service hours for services listed above that are not received by or associated directly with individuals or groups of individuals using the z-consumer ConsumerId code and report them as NC services. For NC services, if the ConsumerId in the Service file does not start with a z or the service is not listed above, an error will occur. Refer to Appendix F for more information.

## Service Dates

CCS 3 requires that specific dates be identified for a time period during which services are received by an individual. Because CCS 3 reports services with specific dates, they are not aggregated. Two date fields are available. The first date is the date that the service started (service from date); the second is the date that the service ended (service through date). If a service starts and ends on the same date, then the values of both fields would be the same. Allowing for a separate through date enables reporting services that might be reported more efficiently over a longer period than a single day. The through date is not used to calculate units of service; units of service should be those that are actually received, or those service hours provided for z-consumers, during the time period. CCS 3 does not do any calculations involving from and through dates to calculate the units of service. Tables 1 and 2 show the use of the two fields varies by service code.

**Date Provided**

The service codes in this reporting category in Tables 1 and 2 are reported for the specific date using the ServiceFromDate field. The value of the ServiceFromDate must also be copied into the ServiceThroughDate field in the extract so that the two fields show that the service starts and ends on the same date. For example, if an individual received three hours of outpatient services on March 1, 2019, the CSB would report a single service record for three hours of outpatient services with a ServiceFromDate of 03012019 and a ServiceThroughDate of 03012019.

**Data element 106 (eff. 7/1/18),** Service Modality, requires each service hour unit of service (core service codes 100, 310, 312, 313, 318, 320, 335, 350, 390, 460, 581, 610, 620, and 720) be identified as face-to-face or non-face-to-face. Thus, for services in Tables 1 and 2 where service units are reported "On that date," CSBs can aggregate multiple service units of the same type of face-to-face service provided on the same day into a single face-to-face service record, but they must send a separate face-to-face service record for each day on which these services are provided. Similarly, CSBs can aggregate multiple service units of the same type of non-face-to-face service provided on the same day into a single non-face-to-face service record, but they must send a separate non-face-to-face service record for each day on which these services are provided. Alternatively, CSBs can send a separate service record for each face-to-face or non-face-to-face service unit provided on the same day. **CSBs cannot submit service hour service records that aggregate service units for multiple days in a month.**

With the addition of this new Service Modality data element, (Version 7.4) eliminates all of the face-to-face and non-face-to-face codes in data element 64, Service Subtype, for developmental case management services. Now, data element 64 includes only quarterly case management ISP reviews and annual case management ISP meetings as service subtypes for developmental case management services. CSBs must use Not Applicable (code 96) for any developmental case

management services that do not involve quarterly case management ISP reviews or annual case management ISP meetings. Refer to data element 64 for additional information.

**From/Through Date**

The service records in this reporting category in Tables 1 and 2 will have separate values in each date field. The ServiceFromDate field identifies the day the provision or receipt of service begins, and the ServiceThroughDate field identifies the day the provision or receipt of service ends. These fields are inclusive; they include services provided on those days. A day represents a normal 24 hour time period from 12:00 a.m. to 12:00 a.m. (midnight to midnight). CCS 3 Business Rules about service dates include the following requirements.

- For services provided during an admission to a program area, the ServiceFromDate must be a date equal to or greater than the TypeOfCareFromDate, and the ServiceThroughDate must be a date equal to or less than the TypeOfCareThroughDate. If the TypeOfCareThroughDate is blank, the ServiceThroughDate must be a date less than or equal to the end of the current reporting month. In other words, the dates of the service must fall within the dates of the corresponding type of care for the program area.
- The ServiceThroughDate must be a date greater than or equal to the ServiceFromDate, unless it is blank. The ServiceThroughDate can be blank **only** if the CSB is technically unable to provide the ServiceThroughDate.
- Service records cannot span multiple months. If a service spans multiple months, then a CSB must create a separate service record at the start of each month that the service is provided. The ServiceThroughDate cannot be greater than the last day of the reporting month.

For example, if a CSB began serving an individual in a group home on December 15, 2018, and the individual was still receiving services at the end of the month, the extract for December would have a service record that showed 17 bed days of intensive residential services (service code 521) for the 15th through 31st. The ServiceFromDate would be 12152018; the ServiceThroughDate would be 12312018. If the individual was still receiving services in January, but left the group home on January 14, 2019, there would be a service record in January with a ServiceFromDate of 01012019, a ServiceThroughDate of 01142019, and service units of 14 bed days (the 1st through14th). If this same individual ended his or her intensive residential services on December 22, 2018, then there would be one service record extracted for December showing a ServiceFromDate of 12152018, a ServiceThroughDate of 12222018, and service units of eight bed days (the 15th through 22nd).

# Community Consumer Submission 3 Extract Specifications: Version 7.5

## Service Date Reporting Categories

The service codes and their corresponding reporting categories are broken out in the following tables in the order in which they are listed in the current core services taxonomy.

| Service Code | Table 1: Emergency and Ancillary Services | | Reporting Category |
|---|---|---|---|
| | Core Service Name | Reported Units Provided | |
| 100 | Emergency Services | On that date | Date provided |
| **Ancillary Services** | | | |
| 318 | Motivational Treatment Services | On that date | Date provided |
| 390 | Consumer Monitoring Services | On that date | Date provided |
| 620 | Early Intervention Services | On that date | Date provided |
| 720 | Assessment and Evaluation Services | On that date | Date provided |

| Service Code | Table 2: Services Available at Admission to a Program Area | | Reporting Category |
|---|---|---|---|
| | Core Service Name | Reported Units Provided | |
| 250 | Acute Psychiatric or Substance Use Disorder (SUD) Inpatient Services | Over that period of time | From/through date |
| 260 | Community-Based SUD Medical Detoxification Inpatient Services | Over that period of time | From/through date |
| 310 | Outpatient Services | On that date | Date provided |
| 312 | Medical Services | On that date | Date provided |
| 313 | Intensive Outpatient Services | On that date | Date provided |
| 320 | Case Management Services | On that date | Date provided |
| 335 | Medication Assisted Treatment | On that date | Date provided |
| 350 | Assertive Community Treatment | On that date | Date provided |
| 410 | Day Treatment or Partial Hospitalization | Over that period of time | From/through date |
| 420 | Ambulatory Crisis Stabilization Services | Over that period of time | From/through date |
| 425 | Rehabilitation or Habilitation | Over that period of time | From/through date |
| 430 | Sheltered Employment | Over that period of time | From/through date |
| 460 | Individual Supported Employment | On that date | Date provided |
| 465 | Group Supported Employment | Over that period of time | From/through date |
| 501 | Highly Intensive Residential Services | Over that period of time | From/through date |
| 510 | Residential Crisis Stabilization Services | Over that period of time | From/through date |
| 521 | Intensive Residential Services | Over that period of time | From/through date |
| 551 | Supervised Residential Services | Over that period of time | From/through date |
| 581 | Supportive Residential Services | On that date | Date provided |
| 610 | MH or Developmental Prevention Services | On that date | Date provided |

# Community Consumer Submission 3 Extract Specifications: Version 7.5

## Type of Care and Episode of Care

### Episode of Care Description

The core services taxonomy defines an episode of care as all of the services provided to an individual to address an identified condition or support need over a continuous period of time between an admission and a discharge. An episode of care begins with an admission to a program area, and it ends with the discharge from that program area. An episode of care may consist of a single face-to-face encounter or multiple services provided through one or more programs. CSBs must not admit an individual to emergency or ancillary services; those services are outside of an episode of care. If an individual has received his or her last service but has not yet been discharged from a program area, and he or she returns for services in that program area within 90 days, the individual is not readmitted, since he or she has not been discharged; the individual is merely accepted into that program area for the needed services.

### Type of Care Description

In CCS 3, type of care is used to represent a time period between a beginning and an ending point in time or a from date and a through date. A type of care in CCS 3 includes an episode of care, which is just one example of a type of care. A type of care is any time period with the following characteristics.

- It is bounded by a starting point and an ending point, both of which are specific dates.
- It represents a point in time at which to view the status of the individual receiving services.
- It is a marker after which the data input requirements in the CCS change. These markers determine what specific pieces of data are to be reported, as documented in Appendix D, to identify "When is Data Collected"?

The TypeOfCare file in CCS 3 represents a type of care. The TypeOfCare file includes records that represent:

- an episode of care (*i.e.*, an admission to and discharge from a program area),
- a consumer designation code indicating that an individual is participating in a special project, program, or initiative indicated by a 900 code, or
- any other type of care that meets any of the three characteristics above.

### Episode of Care and Program Area

In CCS 3, an episode of care in any of the three program areas represents an admission to and discharge from that program area. In CCS 3, there are no admissions to or discharges from a CSB or a particular service, only to or from a program area. Individuals can have an unlimited number of episodes of care, although at any given point in time they must be in only one episode of care for any one program area at any given CSB. A current episode of care is one in which the through date is null. A previous episode of care is one in which the through date is less than or equal to the current date or last day of the extract month. For example, if an individual is receiving treatment for co-occurring mental illnesses and substance use disorders, he or she will have one mental health episode of care and one substance use disorder episode of care and may have any number of previous episodes of care.

Episodes of care in different program areas can overlap; there is no requirement that an episode of care end in one program area before another episode of care begins in a different program area. However, episodes of care cannot overlap in the same program area; CSBs must not submit TypeOfCare records for more than one episode of care in the same program area at the same time. Admission to a program area admits an individual to any of the services in that program area; there is no separate admission to a service or individual program within that program area.

**Type of Care and Consumer Designation Codes (CDCs)**

The core services taxonomy establishes consumer designation codes to identify individuals who receive services in specific initiatives or projects. These codes are not service codes per se, like 310 is the core services code for outpatient services; instead, they reflect a particular status of those individuals. The core services taxonomy includes the following consumer designation codes:

905 - Mental Health Mandatory Outpatient Treatment (MOT) Orders,
910 - Discharge Assistance Program (DAP),
915 - Mental Health Child and Adolescent Services Initiative,
916 - Mental Health Services for Children and Adolescents in Juvenile Detention Centers,
918 - Program of Assertive Community Treatment (PACT),
919 - Projects for Assistance in Transition from Homelessness (PATH),
920 - Developmental Disability (DD) Home and Community-Based Waiver Services (HCBS) – Medicaid funded
923 – Developmental Disability Enhanced Case Management Services (DD-ECM)
933 - Substance Use Disorder Medication Assisted Treatment, and
935 - Substance Use Disorder Recovery Support Services.
936 – Project LINK (if applicable to the specific CSB)

CSBs must use consumer designation code (CDC) 920 only for individuals who have been admitted to the developmental services program area (200) and are receiving services under any of the three Medicaid developmental disability (DD) waivers (Building Independence, Family and Individual Supports, or Community Living) directly from a CSB, from other agencies or individuals contracted by the CSB where the CSB remains the provider for DMAS payment purposes, or from any other provider of Medicaid DD waiver services that is reimbursed directly by DMAS. If it provides DD waiver services to an individual, the CSB must admit the individual to the developmental services program area (200), assign a 920 CDC, and report any DD waiver services it provides to the individual directly or through contracts with other providers of DD waiver services. The CSB reports the DD waiver services in CCS 3 using the core services taxonomy crosswalk at http://www.dbhds.virginia. gov, under the Offices tab, under Office of Management Services.

These requirements apply to the CSB even if the individual is in a waiver slot assigned to a different CSB. The CSB to which a waiver slot has been assigned and filled must admit the individual in the slot to the developmental services program area (200), assign a 920 CDC, and provide developmental case management services (320) to the individual directly or through a contract with another developmental case management services provider. The CSB must do this whether or not it provides any DD waiver services to the individual directly or through other agencies or individuals contracted by the CSB where the CSB remains the provider for DMAS payment purposes.

The 923 CDC captures data about developmental enhanced case management (ECM) services previously collected using data element 90 in the consumer.txt file. It indicates if an individual who

is receiving Medicaid DD Waiver services meets the criteria for receiving ECM services. ECM means the individual receives at least one face-to-face visit monthly with no more than 40 days between visits and at least one such visit every other month is in the individual's place of residence. An individual who meets any of the following criteria must receive ECM services:

- receives services from providers that have conditional or provisional licenses from the Department,
- has more intensive behavioral or medical needs as defined by the Supports Intensity Scale category representing the highest level of risk,*
- has an interruption of services longer than 30 days,
- encounters the crisis system for a serious crisis or for multiple less serious crises within a three-month period,
- has transitioned from a state training center within the previous 12 months, or
- resides in a congregate setting of five or more beds.*

* as identified in Case Management Operational Guidelines and updates issued by the Department.

Beginning July 1, 2018, rather than using data element 90, CSBs will use the 923 CDC to report when an individual meets the criteria for ECM or no longer meets those criteria. Whenever an individual meets the ECM criteria, a CSB shall report this in a TypeOfCare record with a 923 CDC and a TypeOfCareFromDate for the start of meeting the criteria. Whenever an individual no longer meets the criteria, a CSB shall report this using a new TypeOfCare record with a 923 CDC and a TypeOfCareThroughDate for the end of meeting the criteria. If a CSB is providing Medicaid DD Waiver services to an individual but not developmental case management services to that individual, the CSB must not submit a TypeOfCare record for ECM since it is not providing case management services to that individual. The CSB that is providing developmental case management services to that individual must submit a TypeOfCare record for ECM if that individual meets the criteria for ECM.

The component services of these projects or initiatives are included in the appropriate core services and numbers of individuals in those initiatives are counted in the CCS in the following manner. When an individual receives services in any of the initiatives listed above, the CSB must enter the consumer designation code for the initiative in a type of care record for the individual. CSBs will accumulate and record units of service for these initiatives in the applicable core services associated with the initiative, such as outpatient, case management, day treatment or partial hospitalization, rehabilitation or habilitation, or various residential services.

A CSB must create a type of care record in the TypeOfCare file for each individual receiving a service in one of these initiatives or projects. The CSB must enter the consumer designation code in the TypeOfCare field. This record must be created when an individual first receives a service in one of these initiatives or projects with a TypeOfCareFromDate when an individual enters into or participates in one of those initiatives or projects, thus starting his or her type of care, and when the individual leaves or stops participating in the initiative or project with a TypeOfCareThroughDate.

Normally the CSB must create a type of care record for a program area episode of care before creating a type of care record for a consumer designation code. In other words, A CSB must admit an individual to a program area before assigning a consumer designation code to the individual. However, this rule does not apply to the following codes and situations:

- Mental Health Mandatory Outpatient Treatment (MOT) Orders (905) when the CSB only monitors the individual's compliance with the MOT order,

- Discharge Assistance Program (DAP) (910) because the hospital discharge date and related DAP TypeOfCareFromDate may precede the TypeOfCareFromDate for admission to the mental health services program area,
- Mental Health Services for Children and Adolescents in Juvenile Detention Centers (916) when the CSB only provides emergency or ancillary services,
- Projects for Assistance in Transition from Homelessness (PATH) (919) because PATH is included in consumer monitoring services, an ancillary service, and
- Substance Use Disorder Recovery Support Services (935) if the individual only receives emergency or ancillary services.

## Extract Files

Each CSB extracts data from its information system or EHR into five separate ASCII comma delimited extract files: Consumer, TypeOfCare, Service, Diagnosis, and Outcomes. Each record in a file must have an Agency Code that will identify the record as belonging to the particular CSB. Appendix C describes the data elements in those files in more detail and with acceptable values.

## Consumer File (Consumer.txt)

The Consumer extract file contains a record for each individual that represents a snapshot of the individual receiving services at a point in time. It contains identifying, demographic, and status or descriptive information about the individual.

## Extract Schedule and Individual Status Changes

The CCS is a batch system, and CSBs produce and transmit extracts to the Department each month. Because consumer records are extracted monthly, they will contain information about individuals at the time the extract is run. It is possible that an individual's status may have changed more than once during the month, but those changes will not be captured in the extract; only the status that is current when the extract is run will be submitted to the Department. If an individual's status for any Consumer file data element changes during a month, the change must be recorded in the CSB's information system or EHR so it can be extracted for the Consumer file in the monthly CCS extract.

At the Department, the Central Office CCS database will use monthly extract submissions to record changes in an individual's status over time and will maintain a separate record for each individual's change in status, with a different artificial key identifying each consumer record. This will allow the Department to track the history of changes in an individual's status and relate them to specific service dates. However, this happens in the Department's CCS database and does not affect the local CSB extract process.

### Extract Criteria

CSBs must send consumer records to the Department each month for any individuals who within the current fiscal year:

- received an emergency or ancillary service (services available outside of a program area), OR
- were admitted to a program area and received a service, OR

- were discharged from a program area with or without receiving a service.

A Consumer.txt file extract record for an individual must contain all the current values in all of the applicable data elements for that individual at the time of extract.

## Type of Care File (TypeOfCare.txt)

### Extract Criteria

CSBs must send all type of care records to the Department each month for all individuals who within the current fiscal year or across fiscal years (see the note at the top of the next page):

- were admitted to a program area and were not discharged, OR
- were discharged with or without receiving a service, OR
- received or lost a consumer designation code; for example, began or stopped participating in a PACT (918) or started or ended meeting the criteria for ECM.

CSBs must send TypeOfCare records only for these three circumstances.

The FromDate in a TypeOfCare record containing a consumer designation code must be the date on which an individual first began participating in the specialized initiative or project, and the ThroughDate must be the date on which the individual stopped participating in the specialized initiative or project. If an individual receives a consumer designation code in one fiscal year and continues participating in that specialized project or initiative in the following fiscal year, all of the TypeOfCare records related to that consumer designation code would contain a FromDate but no ThroughDate, until the individual's participation ended. This enables the correct calculation of the days that an individual participated in the specialized project or initiative, and it supports accurate reporting of when the individual began and ended his or her participation in the initiative or project. Note: If an individual admitted to a program area has not received any service within 100 days since the last service he or she received and has not been discharged, the CSB shall attempt to contact and re-engage him or her. If it cannot contact or re-engage the individual within 30 days from the end of the 100-day period, the CSB shall discharge him or her and report the discharge using a TypeOfCare record with a through date of the date of the last service he or she received.

CSBs must not submit TypeOfCare records containing consumer designation codes with Through Dates for all of the individuals currently participating in specialized projects or initiatives at the end of the current fiscal year and new TypeOfCare records with FromDates on the first day of the next fiscal year for all of the same individuals. This would create erroneous TypeOfCare records.

## Service File (Service.txt)

The current core services taxonomy defines all services and service units that are included in CCS 3 extracts, and the Core Services Taxonomy Category and Subcategory Matrix and Appendix F list the unit of service for each service.

### Extract Criteria

CSBs must send service records to the Department each month for all services they provided directly or contractually during the current fiscal year. Each service extract must contain records for all services delivered during the fiscal year. For example, the service file for July would include the service records for July; the service file for August would include the service records for July and for August; the service file for September would include the service records for July, for August, and for September; and so on. The service file grows during the year until at the end of the fiscal year it includes all the records for that fiscal year.

The Service Units field reports the services received on the service date or dates; it must not accumulate or total service units at a higher amount than on that date or those dates. For example, it must not represent the total service units for more than one month. In situations where the same service is provided to an individual at multiple times during the same day, CSBs may opt to report these records individually, or CSBs may summarize the units for the day in a single record except for developmental case management services. See the ***Date Provided*** section on page 5 for more details.

## Diagnosis File (Diagnosis.txt)

The Diagnosis extract file contains one or more records for each individual that represent a snapshot of his or her diagnoses. It contains identifying and diagnostic information about the individual. There may be multiple diagnosis records for an individual, but there must be at least one record. The Diagnosis file will accept DSM-5 mental illness, developmental disability, or substance use disorder codes for historical purposes and ICD-10 mental illness, developmental disability, substance use disorder, and medical codes.

### Extract Criteria

CSBs must send diagnosis records to the Department each month for any individuals who within the current fiscal year:

- received an emergency or ancillary service (services available outside of a program area), OR
- were admitted to a program area and received a service, OR
- were discharged from a program area with or without receiving a service.

A Diagnosis.txt file extract record for an individual must contain all the current values in all of the applicable data elements for that individual at the time of extract. Each diagnosis record in the Diagnosis extract file must contain a DiagnosisStartDate (data element 94).

## Outcomes File (Outcomes.txt)

The Outcomes extract file contains a record for each outcome measure reported for individuals receiving services. It contains the ConsumerId to link this record to other files such as records in Consumer and Service files for an individual. It also reports data about the date and type of assessment used for the measure and the numeric value of the assessment.

### Extract Criteria

CSBs must send Outcomes records to the Department each month for any individuals who received services from them within the current fiscal year whenever CSBs perform assessments on them to gather data for an outcome measure. An Outcomes.txt file extract record for an individual must contain all the current values in all of the applicable data elements for that individual at the time of extract.

## Submission Procedures and Processes

## Timeliness

CSBs must submit all CCS data on a monthly basis. Unless otherwise directed, extract data must be received at the Department no later than the end of the month following the month of the extract. For example, November data is due in the Department no later than December 31. When it will not make a scheduled submission on time, the CSB must notify the Susan Elmore, PhD, Special Projects Coordinator at Susan.Elmore@dbhds.Virginia.gov, 804-371-2478 (o); 804-240-1019 (cell) preferably by email, alternate by phone, and provide a revised delivery date. The Department will monitor and report on compliance with the monthly reporting requirements. Semi-monthly disbursements of state and federal funds by the Department to CSBs are contingent on the Department's receipt of monthly CCS submissions.

## Protocol for Resubmitting a CCS 3 Extract

The community services performance contract requires each CSB to submit monthly CCS 3 extracts containing consumer, type of care, service, diagnosis, and outcome files that contain records reporting individual consumer characteristic, service, and other data to the Department. Each CSB must submit these extracts to the Department by the end of the month following the month for which the data is being submitted, except for the complete CSB fiscal year extract. Refer to Exhibit E of the performance contract for additional information. If the Department identifies a problem with a monthly CSB extract submission and the Department's Special Projects Coordinator, Susan Elmore determines that a resubmission is necessary, the subsequent CSB resubmission is exempt from this protocol. Although CSBs must provide complete and accurate information in their monthly extract submissions, occasionally, it may be necessary for a CSB to resubmit a monthly CCS extract submission in order to correct inaccurate or incomplete service, consumer, type of care, diagnosis, or outcomes records submitted during the month or to replace an incorrectly named or corrupted file.

CSBs cannot resubmit an extract for any month that precedes its most recent submission. If a CSB determines that it needs to resubmit its CCS 3 extract for the current month, it shall follow the steps below to request a resubmission.

1. The designated CCS 3 contact person at the CSB e-mails Susan Elmore, PhD, the Department's Special Projects Coordinator at Susan.Elmore@dbhds.virginia.gov, who is designated CCS 3 business owner or designee, describing and justifying its request for a resubmission.
2. The CCS 3 business owner, Susan Elmore or designee may seek additional information from the CSB to understand the request and its potential impact if the CSB did not make the resubmission.
3. The CCS 3 business owner, Susan Elmore or designee will review each request on a case-by-case basis with the Department's I &T staff as soon as possible.
4. The CCS 3 business owner, Susan Elmore or designee will communicate its decision and any instructions related to the resubmission, if necessary, to the requesting CSB.

5. If the Department approves the request, the CSB will resubmit its extract for that month to the Department via the sFTP secure server.

## Security

Security of the data during transmission from the CSB to the Department is the responsibility of the Department. Authorized CSB users will transmit data to the Department's secure FTP site, which will ensure compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and community services performance contract requirements.

## Quality Control Responsibilities

Each CSB is responsible for:

- ensuring that each record in the data submission contains the required key fields, all fields in the record contain valid codes, and no duplicate records are submitted;
- cross-checking data items for consistency across data fields; and
- responding promptly to CCS error reports by correcting data locally so that the next extract will contain correct, accurate, and complete data or by resubmitting data where appropriate.

The Department is responsible for:

- processing CSB data submissions promptly into the CCS data base;
- checking each record submitted to verify that all CCS key fields are valid;
- creating quality improvement reports that CSBs can run locally on the extract files before they have been submitted and processed and providing monthly data quality reports on data after it has been received and processed by the Department.

### CCS Extracts Submitted for a New Fiscal Year

When beginning the cycle of extract submissions for a new fiscal year, a CSB shall drop the following records from its extracts:

- service records prior to July 1 of the new fiscal year,
- type of care records with discharge dates prior to July 1 of the new fiscal year,
- consumer records for individuals discharged from all program areas (mental health, developmental, and substance use disorder) prior to July 1 of the new fiscal year,
- consumer records for individuals with open cases but not admitted to a program area who have not received a service on or after July 1 of the new fiscal year, and
- diagnosis records for individuals whose consumer records have been dropped (preceding two criteria).

# Community Consumer Submission 3 Extract Specifications: Version 7.5

## Appendix A: Extract Lookup Tables

CCS extract lookup tables used by CSBs and validated by the CCS 3 extract software are listed below. Each begins with a three-character prefix, lkp. The enumeration of each value in each lookup table is not included here for brevity. However, the values in most lookup tables are shown under the data elements that rely on them in Appendix C. If there is any conflict between those values and the values in the lookup tables, the value in the lookup table will take precedence.

| CCS 3 Extract Lookup Tables | |
|---|---|
| **Lkp Table Name** | **Lookup Table Description** |
| lkpAgency | Three character code identifying a CSB |
| ~~lkpCognitive~~ | ~~Code indicating whether the individual has a cognitive delay~~ |
| lkpDisStatus | Code indicating the status of the individual at the end of a type of care |
| lkpDrug | Code indicating type of drug used by an individual with a substance use |
| lkpDrugMethod | Code indicating the method of drug use or usual route of administration |
| lkpEducation | Code indicating the highest-grade level completed by the individual |
| lkpEmployment | Code indicating the involvement of the individual in the labor force |
| lkpEmployDiscuss | Code indicating whether an employment discussion occurred during annual case management ISP meeting or update |
| lkpEpisodes | Code indicating the number of previous episodes of care in any drug or alcohol program for the individual |
| lkpFIPS | Federal code indicating the city or county in which the individual lives. NOTE: change 998 to Homeless (i.e., truly homeless population) |
| lkpFrequency | Code indicating the frequency of use for a substance use disorder |
| lkpGender | Code indicating the gender of the individual receiving services |
| lkpGoalMeasure | Code indicating extent to which a goal measure is achieved or implemented. |
| lkpHispanic | Code indicating the individual's Hispanic origin |
| lkpHousingMoves | Code indicating the number of times an individual has moved |
| lkpInsuranceType | Code indicating the individual's current type of insurance coverage |
| lkpLanguage | Code indicating preferred language used by the individual receiving services |
| lkpLegal | The individual's legal status in relation to the receipt of services |
| ~~lkpMaritalStatus~~ | ~~Code indicating the current marital status of the individual.~~ |
| lkpMilitaryStatus | Code indicating the current status of an individual who is serving or has served in a U.S. military branch or who is a dependent family member |
| lkpOutcomeAction | Code indicating the type of assessment for an outcome measure |
| lkpOutcomeFreq | Code indicating the frequency of the outcome assessment or action |
| lkpProgram | Identifier for a program area or pseudo program area |
| lkpRace | Code indicating the self-identified race of the individual receiving services |
| lkpReferral | Code indicating person, agency, or organization that referred individual to a |
| lkpResidence | Code indicating where the individual receiving services lives |
| lkpService | The three-character core services taxonomy code for a service |
| lkpServiceLocation | Code indicating location at which a service was received by the individual |
| lkpServiceMod | Code indicating face-to-face or non-face-to-face service hour unit of service. |
| lkpServiceSubtype | Code indicating a specific activity associated with a particular core service |
| lkpSMISED | Code indicating if the individual has a SMI, SED, or is at-risk of SED |
| lkpSocial | Code indicating the frequency of the individual's participation in social contacts |
| lkpStabilityMeasure | Code indicating extent to which a stability measure is maintained. |
| lkpTypeOfCare | Code indicating the type of care program area or consumer designation |
| lkpYesNo | Code indicating yes, no, not applicable, unknown, or not collected |

| | |
|---|---|
| lkpYesNoECM | Code indicating yes, no, not applicable, or not collected for data elements 92, 96, and 98 |
| lkpReferralDestination | Code indicating referral of the individual from the CSB (Appendix J) |

# Community Consumer Submission 3 Extract Specifications: Version 7.5

## Appendix B: CCS 3 Extract File Layouts

Listed below are the file layouts for the five files each CSB produces as part of the initial extract process from the CSB's information system or EHR. As the first or original set of extract files, they are identified as Data Set 1 (DS1). These files are then used as input to subsequent processing, including hashing or transforming sensitive identifying information about individuals receiving services, before transmission of the extracted data to the Department. Full definitions, descriptions, and validations of each of these data elements are contained in Appendix C: CCS 3 Extract Data Element Definitions.

The No. column refers to the data element number. CCS 3 carries the numbers forward from CCS 2 as much as possible. The order of the fields follows the order of CCS 2 as much as possible, with new fields in CCS 3 generally added to the end of the file layout.

| Consumer File (Consumer.txt) | | | | |
|---|---|---|---|---|
| **No.** | **Field Name** | **Type** | **Length** | **Description** |
| 2 | AgencyCode | Text | 3 | Code identifying a CSB (*e.g.*, 049, 031) |
| 7 | ConsumerId | Text | 10 | Identifier assigned by the CSB to an individual who is or will be receiving services |
| 8 | SSN | Text | 9 | Social security number of the individual; this raw value will be hashed before transmission |
| 16 | DateOfBirth | Text | 8 | MMDDYYYY of the individual's birth date |
| 17 | Gender | Text | 2 | Code indicating the gender of the individual |
| 18 | Race | Text | 2 | Code indicating the race of the individual |
| 19 | HispanicOrigin | Text | 2 | Code indicating Hispanic origin of the individual |
| 13a | SMISEDAtRisk | Text | 2 | Code indicating if the individual has serious mental illness (SMI), serious emotional disturbance (SED), or is at-risk of SED |
| ~~13b~~ | ~~CognitiveDelay~~ | ~~Text~~ | ~~2~~ | ~~Code indicating whether the individual is a child who is at least three but less than six years old and has a confirmed cognitive delay within one year of assessment, but does not have an intellectual disability diagnosis~~ |
| ~~26~~ | ~~AxisICode1~~ | ~~Text~~ | ~~5~~ | ~~DSM Axis I diagnosis, code 1~~ |
| ~~27~~ | ~~AxisICode2~~ | ~~Text~~ | ~~5~~ | ~~DSM Axis I diagnosis, code 2~~ |
| ~~52~~ | ~~AxisICode3~~ | ~~Text~~ | ~~5~~ | ~~DSM Axis I diagnosis, code 3~~ |
| ~~53~~ | ~~AxisICode4~~ | ~~Text~~ | ~~5~~ | ~~DSM Axis I diagnosis, code 4~~ |
| ~~54~~ | ~~AxisICode5~~ | ~~Text~~ | ~~5~~ | ~~DSM Axis I diagnosis, code 5~~ |
| ~~55~~ | ~~AxisICode6~~ | ~~Text~~ | ~~5~~ | ~~DSM Axis I diagnosis, code 6~~ |
| ~~28~~ | ~~AxisIIPrimary~~ | ~~Text~~ | ~~5~~ | ~~DSM Axis II primary diagnosis code~~ |
| ~~29~~ | ~~AxisIISecondary~~ | ~~Text~~ | ~~5~~ | ~~DSM Axis II secondary diagnosis code~~ |
| ~~30~~ | ~~AxisIII~~ | ~~Text~~ | ~~1~~ | ~~DSM Axis III diagnosis (Y/N)~~ |
| ~~31~~ | ~~AxisV~~ | ~~Text~~ | ~~3~~ | ~~DSM Axis V diagnosis code~~ |
| 14 | CityCounty ResidenceCode | Text | 3 | Federal (FIPS) code indicating the city or county in which the individual lives |

| Consumer File (Consumer.txt) - *continued* | | | | |
|---|---|---|---|---|
| **No.** | **Field Name** | **Type** | **Length** | **Description** |
| 15 | ReferralSource | Text | 2 | Code indicating person, agency, or organization that referred individual to the CSB for evaluation or treatment |
| 22 | EmploymentStatus | Text | 2 | Code indicating the individual's employment status |
| 21 | EducationLevel | Text | 2 | Code indicating the individual's education level |
| 24 | LegalStatus | Text | 2 | Code indicating the individual's legal status |
| 25 | NbrPriorEpisodes AnyDrug | Text | 2 | Code indicating the number of previous episodes in any drug or alcohol program for the individual |
| 44 | PregnantStatus | Text | 1 | Code indicating if the individual is a female with a substance use disorder who is pregnant. |
| 45 | FemaleWith Dependent ChildrenStatus | Text | 1 | Code indicating if the individual is a female with a substance use disorder who is living with dependent children |
| ~~46~~ | ~~DaysWaitingTo EnterTreatment~~ | ~~Text~~ | ~~3~~ | ~~Code indicating the number of calendar days from the first contact or request for service until the first scheduled appointment in a substance abuse service accepted~~ |
| 47 | NbrOfArrests | Text | 2 | Number of arrests in the past 30 days |
| 32 | SAPDType | Text | 2 | SA primary drug: type of drug code |
| 34 | SAPDMethUse | Text | 2 | SA primary drug: method of use code |
| 33 | SAPDFreqUse | Text | 2 | SA primary drug: frequency of use code |
| 35 | SAPDAgeUse | Text | 2 | SA primary drug: age of first use code |
| 36 | SASDType | Text | 2 | SA secondary drug: type of drug code |
| 38 | SASDMethUse | Text | 2 | SA secondary drug: method of use code |
| 37 | SASDFreqUse | Text | 2 | SA secondary drug: frequency of use code |
| 39 | SASDAgeUse | Text | 2 | SA secondary drug: age of first use |
| 40 | SATDType | Text | 2 | SA tertiary drug: type of drug code |
| 42 | SATDMethUse | Text | 2 | SA tertiary drug: method of use code |
| 41 | SATDFreqUse | Text | 2 | SA tertiary drug: frequency of use code |
| 43 | SATDAgeUse | Text | 2 | SA tertiary drug: age of first use |
| ~~49~~ | ~~AuthRep~~ | ~~Text~~ | ~~1~~ | ~~Code indicating presence of an authorized representative~~ |
| 57 | MedicaidNbr | Text | 12 | The individual's Medicaid number in the format prescribed by the DMAS |
| 58 | Consumer FirstName | Text | 30 | The first name of the individual, used to generate a unique consumer ID; the full name is not transmitted to the Department |
| 59 | ConsumerLastName | Text | 30 | The last name of the individual, used to generate a unique consumer ID; same as No. 58 |
| 66 | MilitaryStatus | Text | 2 | Current status of an individual serving in or who has served in the military or who is a dependent family member of the individual |
| 67 | MilitaryService StartDate | Text | 4 | The year in which the individual's most recent active or reserve duty began |

| Consumer File (Consumer.txt) - *continued* | | | | |
|---|---|---|---|---|
| **No.** | **Field Name** | **Type** | **Length** | **Description** |
| 68 | MilitaryService EndDate | Text | 4 | The year in which the individual's most recent active or reserve duty ended |
| ~~69~~ | ~~MaritalStatus~~ | ~~Text~~ | ~~2~~ | ~~The individual's current marital status~~ |
| 70 | Social Connectedness | Text | 2 | Measure of frequency of participation in social contacts that support recovery |
| 71 | InsuranceType1 | Text | 2 | The type of the individual's current insurance coverage |
| 72 | InsuranceType2 | Text | 2 | The type of the individual's current insurance coverage |
| 73 | InsuranceType3 | Text | 2 | The type of the individual's current insurance coverage |
| 74 | InsuranceType4 | Text | 2 | The type of the individual's current insurance coverage |
| 75 | InsuranceType5 | Text | 2 | The type of the individual's current insurance coverage |
| 76 | InsuranceType6 | Text | 2 | The type of the individual's current insurance coverage |
| 77 | InsuranceType7 | Text | 2 | The type of the individual's current insurance coverage |
| 78 | InsuranceType8 | Text | 2 | The type of the individual's current insurance coverage |
| ~~79~~ | ~~DateNeedforMH ServicesFirstDeter~~ | ~~Text~~ | ~~8~~ | ~~Date on which CSB staff first determined the individual needs MH services~~ |
| ~~80~~ | ~~DateNeedforSUD ServicesFirstDeter~~ | ~~Text~~ | ~~8~~ | ~~Date on which CSB staff first determined the individual needs substance use disorder services~~ |
| 81 | HealthWellBeing | Text | 2 | Extent to which the individual remains healthy |
| 82 | CommunityInclusion | Text | 2 | Extent to which outcomes in the individual's ISP are met |
| 83 | ChoiceandSelf Determination | Text | 2 | Extent to which life choices in the individual's ISP have been implemented |
| 84 | LivingArrangement | Text | 2 | Degree to which individual has maintained arrangement |
| 85 | DayActivity | Text | 2 | Degree to which individual has maintained activities |
| 86 | SchoolAttendance | Text | 2 | School attendance during past three months |
| 87 | IndependentLiving | Text | 1 | Living independently or dependently in private residence |
| 88 | HousingStability | Text | 2 | Number of changes in residence during a quarter |
| 89 | PreferredLanguage | Text | 2 | Preferred language used by individual receiving services |
| ~~90~~ | ~~EnhancedCaseMgmt~~ | ~~Text~~ | ~~1~~ | ~~Identifies individuals who meet ECM criteria~~ |
| 91 | Employment Discussion | Text | 2 | Employment discussed at annual case management (CM) ISP meeting |
| 92 | EmplymntOutcomes | Text | 1 | Employment outcomes included in case management ISP |
| ~~93~~ | ~~Reported Diagnosis~~ | ~~Text~~ | ~~7~~ | ~~ICD-10 diagnosis codes for individuals~~ |
| ~~94~~ | ~~DiagnosticStartDate~~ | ~~Text~~ | ~~8~~ | ~~The date the diagnosis started~~ |
| ~~95~~ | ~~DiagnosticEndDate~~ | ~~Text~~ | ~~8~~ | ~~The date the diagnosis ended~~ |
| 96 | DiscussionofLast CompletePhysical | Text | 1 | Case manager asked about the last complete physical examination during annual CM ISP meeting |
| 97 | DateofLastComplete PhysicalExamination | Text | 8 | Date on which the individual received his or her last regularly scheduled complete physical examination |
| 98 | DiscussionofLast SchduledDental | Text | 1 | Case manager asked about the last regularly scheduled dental examination during annual CM ISP meeting |
| 99 | DateofLastScheduled DentalExamination | Text | 8 | Date on which the individual received his or her last regularly scheduled routine preventative dental exam |
| 100 | Community Engage-ment Discussion | Text | 1 | Case manager discussed community engagement or community coaching opportunities during ISP meeting |

| | | | | |
|---|---|---|---|---|
| 101 | Community Engagement Goals | Text | 1 | ISP contains community engagement or community coaching goals |
| 109 | MedicareBI | Text | 1 1 | The Individual's Medicare Beneficiary Identifier (MBI), if the person has Medicare (not the SSN – use new Medicare number distributed in 2018) |

Data elements 26-31, 52-55, 79, 80, 90, and 93-95 are no longer required in the Consumer.txt file, and CSBs must report them as NULL values. CSBs now report diagnoses in the Diagnosis file using data elements 93-95. Data elements 102-104 and 107 (SDA) in the Outcomes.txt file replace data elements 46, 79, and 80. Data elements 13.b, 49, and 69 are no longer required; CSBs must report them as NULL values. Please see instructions in Appendix E for formatting NULL values.

**Type of Care File (TypeOfCare.txt)**

| No. | Field Name | Type | Length | Description |
|---|---|---|---|---|
| 2 | AgencyCode | Text | 3 | Code identifying a CSB (*e.g.*, 049, 031) |
| 7 | ConsumerId | Text | 10 | Identifier assigned by the CSB to an individual who is or will be receiving services; the local consumer Id, not the statewide Id (hashed SSN) |
| 3 | TypeOfCare | Text | 3 | Code indicating the program area (100, 200, or 300) or consumer designation code (*e.g.*, 910, 915, or 923) |
| 12 | DischargeStatus | Text | 2 | Code indicating treatment status of an individual at the end of the type of care, that is at discharge from a program area. |
| 61 | TypeOfCareFromDate | Text | 8 | MMDDYYYY of the starting date of the type of care |
| 60 | TypeOfCareThroughDate | Text | 8 | MMDDYYYY of the ending date of the type of care |
| 108 | TransactionID | Text | 12 | A number that uniquely identifies each type of care record |

**Service File (Service.txt)**

| No. | Field Name | Type | Length | Description |
|---|---|---|---|---|
| 2 | AgencyCode | Text | 3 | Code identifying a CSB (*e.g.*, 049, 031) |
| 7 | ConsumerId | Text | 10 | Identifier assigned by the CSB to an individual who is or will be receiving services |
| 3 | ProgramAreaId | Text | 3 | Code indicating if the individual received this service in a service area (100, 200, or 300 for MH, DD~~V~~, SA) or as emergency or ancillary services (400) |
| 5 | ServiceCode | Text | 3 | Core services taxonomy service code for this service |
| 48 | ServiceFromDate | Text | 8 | MMDDYYYY indicating the start date of the service |
| 10 | Units | Text | 8 | Units of service as specified in the current core services taxonomy: service hours, day support hours, days of service, and bed days; reported with two decimal places (*e.g.*, 1.25, 1.00, etc.) |
| ~~56~~ | ~~ConsumerServiceHours~~ | ~~Text~~ | ~~8~~ | ~~No longer collected; reported as a NULL value~~ |

| | | | | |
|---|---|---|---|---|
| 62 | ServiceThroughDate | Text | 8 | MMDDYYYY indicating the end date of a service If the service started and ended on the same day, this value must be the same as the service from date |
| 63 | StaffId | Text | 10 | The CSB local staff identification number (optional) |
| 64 | ServiceSubtype | Text | 2 | A specific activity associated with a particular core service category or subcategory |
| 65 | ServiceLocation | Text | 2 | The location at which the service was received by or provided to an individual |
| 106 | Service Modality | Text | 2 | This identifies how a service unit is delivered (*i.e.*, face-to-face or non-face-to-face) |
| 108 | TransactionID | Text | 12 | A number that uniquely identifies each service record |

Data element 56 is no longer required in CCS 3; CSBs must report it as a NULL value. Please see instructions in Appendix E for formatting NULL values.

**Diagnosis File (Diagnosis.txt)**

| No. | Field Name | Type | Length | Description |
|---|---|---|---|---|
| 2 | AgencyCode | Text | 3 | Code identifying a CSB (*e.g.*, 049, 031) |
| 7 | ConsumerId | Text | 10 | Identifier assigned by the CSB to an individual who is or will be receiving services |
| 93 | ReportedDiagnosisCode | Text | 7 | Valid DSM-4 or ICD-10 diagnosis code |
| 94 | DiagnosisStartDate | Text | 8 | Date the diagnosis started |
| 95 | DiagnosisEndDate | Text | 8 | Date the diagnosis ended |
| 108 | TransactionID | Text | 12 | A number that uniquely identifies each diagnosis record |

**Outcomes File (Outcomes.txt)**

| No. | Field Name | Type | Length | Description |
|---|---|---|---|---|
| 2 | AgencyCode | Text | 3 | Code identifying a CSB (*e.g.*, 049, 031) |
| 7 | ConsumerId | Text | 10 | Identifier assigned by the CSB to an individual who is or will be receiving services |
| 102 | Date of Assessment | Text | 8 | MMDDYYYY indicating the date on which the assessment used for an outcome measure occurred |
| 103 | Assessment Action | Text | 2 | Describes the type of assessment or action related to the assessment (*e.g.*, follow-up) |
| 104 | Assessment Value | Text | 5 | Displays the numeric value of the assessment |
| 105 | Assessment Frequency | Text | 2 | Displays how often the assessment or action was performed |
| 107 | Related Date | Text | 8 | A date related to an outcome measure |
| 108 | TransactionID | Text | 12 | A number that uniquely identifies each outcomes record |

# Appendix C: CCS 3 Extract Data Element Definitions

This appendix contains definitions and validations of current CCS 3 data elements. Definitions list lookup table names and valid values. Some lookup tables, like ICD10 diagnostic codes, are too big to reproduce here. If there is any conflict between this document and values in the lookup tables, values in the lookup tables take precedence. Each definition contains a line for the purpose(s) of the data element, *e.g.*, meeting federal block grant (FBG), mental health block grant (MHBG), substance abuse block grant (SABG), treatment episode data set (TEDS), or DBHDS Annual Report requirements. CCS 3 Business Rules, incorporated by reference in these specifications, contain additional information needed to collect and report data elements accurately. Some definitions include *italicized explanations* that are not part of the definitions or code values themselves. This table lists current CCS 3 data elements alphabetically with their data element numbers for convenient reference.

**Alphabetical Cross Reference of Data Elements**

| No. | Data Element | No. | Data Element | No. | Data Element | No. | Data Element |
|---|---|---|---|---|---|---|---|
| 2 | Agency Code | 96 | Discussion of Last Complete Physical Examination | 88 | Housing Stability | 89 | Preferred Language |
| 103 | Assessment Action | | | 87 | Independent Living Status | 44 | Pregnant Status |
| 105 | Assessment Frequency | 98 | Discussion of Last Scheduled Dental Examination | 71 | Insurance Type 1 | 3 | Program Area Id |
| 104 | Assessment Value | | | 72 | Insurance Type 2 | 18 | Race |
| 83 | Choice & Self- Determination | 21 | Education Level | 73 | Insurance Type 3 | 15 | Referral Source |
| 14 | City County Residence Code | 16 | Date of Birth | 74 | Insurance Type 4 | 107 | Related Date |
| 100 | Community Engagement or Coaching Discussion | 85 | Day Activity Measure | 75 | Insurance Type 5 | 93 | Reported Diagnosis Code |
| | | 95 | Diagnosis End Date | 76 | Insurance Type 6 | 35 | SAPD Age Use |
| 101 | Community Engagement or Coaching Goals | 94 | Diagnosis Start Date | 77 | Insurance Type 7 | 33 | SAPD Freq Use |
| | | 12 | Discharge Status | 78 | Insurance Type 8 | 34 | SAPD Meth Use |
| 82 | Community Inclusion Measure | | | 24 | Legal Status | 32<br>39 | SAPD Type |
| 58 | Consumer First Name | 91 | Employment Discussion | 84 | Living Arrangement Measure | | SASD Age Use |
| 7 | Consumer Id | 92 | Employment Outcomes | 57 | Medicaid Nbr | 37 | SASD Freq Use |
| 59 | Consumer Last Name | 22 | Employment Status | 109 | Medicare Beneficiary Identifier | 38 | SASD Meth Use |
| 97 | Date Last Complete Physical Examination | 45 | Female With Dependent Children Status | 68 | Military Service End Date | 36 | SASD Type |
| | | | | 67 | Military Service Start Date | 43 | SATD Age Use |
| 99 | Date Last Scheduled Dental Examination | 17 | Gender | 66 | Military Status | 41 | SATD Freq Use |
| | | 81 | Health Well Being Measure | 47 | Nbr Of Arrests | 42 | SATD Meth Use |
| 102 | Date of Assessment | 19 | Hispanic Origin | 25 | Nbr Prior Episodes Any Drug | 40 | SATD Type |

| Alphabetical Cross Reference of Data Elements | | | | | | | |
|---|---|---|---|---|---|---|---|
| **No.** | **Data Element** | **No.** | **Data Element** | **No.** | **Data Element** | **No.** | **Data Element** |
| 86 | School Attendance Status | | | | | | |
| 5 | Service Code | | | | | | |
| 48 | Service From Date | | | | | | |
| 65 | Service Location | | | | | | |
| 106 | Service Modality | | | | | | |
| 64 | Service Subtype | | | | | | |
| 62 | Service Through Date | | | | | | |
| 13a | SMI SED At Risk | | | | | | |
| 70 | Social Connectedness | | | | | | |
| 8 | SSN | | | | | | |
| 63 | Staff Id (optional) | | | | | | |
| 108 | Transaction ID | | | | | | |
| 61 | Type Of Care From Date | | | | | | |
| 60 | Type Of Care Through Date | | | | | | |
| 23 | Type Of Residence | | | | | | |
| 10 | Units | | | | | | |

# CCS 3 Data Element Names, Definitions, and Descriptions

| No. | Data Element Name and Definition | Data Type | Max Length |
|---|---|---|---|
| 2 | **Agency Code:** The number provided by the Department that identifies the CSB providing services to the individual and supplying individual and service data through the CCS. | Text | 3 |
| Must match one of the values in the lookup table, lkpAgency. The table uses leading zeros for two digit CSB numbers to make the field length three characters. | | | |
| **Purposes:** Identify the CSB reporting CCS 3 data and meet federal block grant (FBG: MHBG and SABG) and TEDS reporting requirements. | | | |
| 3 | **Program Area Id:** Indicates in the Service file the program area in which an individual is receiving services. The three program areas are mental health, developmental, and substance use disorder services. Program AreaId 400 is a pseudo program area for emergency or ancillary services. The Type of Care file uses data element 3 in the **TypeOfCare** field to capture program area (100, 200, or 300). | Text | 3 |
| Must match one of the values in the lookup table, lkpProgram. Valid codes are:<br>100 Mental Health Services Program Area<br>200 Developmental Services Program Area<br>300 Substance Use Disorder Services Program Area<br>400 Emergency or Ancillary Services | | | |
| | **Program Area Id** also identifies consumer designation (900) codes (CDC) in the Type of Care file. | Text | 3 |
| When used in the Type of Care file for a CDC, data element 3 must match one of the values in the lookup table, lkpTypeOfCare. | | | |
| **Purposes:** Identify the program area in the service and type of care records and meet FBG, TEDS, and DOJ Settlement Agreement reporting requirements, and report outcome measures adopted by the Department and the VACSB. | | | |
| 5 | **Service Code:** Identifies each core service in which the individual receives services. The current core services taxonomy defines core services, and the Core Services Category and Subcategory Matrix indicates the type of service unit collected and reported for each service and lists each service code. | Text | 3 |
| Must match one of the values in the lookup table, lkpService. CSBs must not submit Service.txt records in CCS 3 for consumer-run, substance use disorder prevention, Mental Health First Aid or suicide prevention, or infant and toddler intervention (Part C) services. | | | |
| **Purposes:** Identify the program area in the service and type of care records and meet FBG and TEDS reporting requirements. | | | |
| 7 | **Consumer Id:** A number or a combination of numerical and alphabetical characters used to identify the individual receiving services uniquely within the CSB; it is the local consumer Id, rather than the statewide Id. | Text | 10 |
| Each CSB assigns and maintains these numbers, which can be up to 10 alphanumeric characters. If an individual returns to the same CSB after discharge from a previous type of care, the CSB should use his or her same ConsumerId again. | | | |
| **Purposes:** Identify the unique individual whose data is being reported in the consumer, type of care, service, diagnosis, and outcomes records; link services to the individual receiving them; and report unduplicated individuals receiving services in the DBHDS Annual Report. | | | |

| No. | Data Element Name and Definition | Data Type | Max Length |
|---|---|---|---|
| 8 | **SSN:** The social security number of the individual receiving services from the CSB. CCS 3 hashes the SSN for HIPAA privacy purposes before transmission to the Department. | Text | 9 |
| The SSN must contain only numbers, it must not contain any separations, dashes, or other special characters. | | | |
| **Purposes:** Identify unique individuals, report unduplicated individuals, and construct unique identifier algorithm for One Source. | | | |
| 10 | **Units:** Amount of service received by the individual in the time period from the ServiceFromDate field to the ServiceThroughDate field. Reported with two decimal places (*e.g.*, 1.25 or 1.00) | Text (decimal) | 8 |
| These units are the numeric measurement of the service received by the individual. Units of measure for this field are service hours, day support hours, days of service, and bed days, as defined in the current core services taxonomy. Units of prevention are collected here for mental health and developmental prevention services using the unidentified z-consumer Id. Valid services and units in each program area and emergency and ancillary services are listed in the valid services table in Appendix F. | | | |
| **Purposes:** Report amounts of services in the Annual Report, calculate unit costs, and meet FBG and TEDS reporting requirements. | | | |
| 12 | **Discharge Status:** Status of an individual at the end of a type of care when he or she is discharged from a program area; this field is captured in a type of care record. The coding of this data element must reflect an individual's status at the end of an episode of care when the CSB discharges the individual from a program area, not when the individual moves among core services within a program area. | Text | 2 |
| Must match one of the values in the lookup table, lkpDisStatus. Valid codes are:<br>01 Retired: Assessment and evaluation services are ancillary services; this code is not available for use by the CSB and is hidden in the extract software. Individuals for whom CSBs used this value previously should be reported as 07.<br>02 Treatment Completed: Individual discharged from a program area having made significant progress toward completing current ISP goals.<br>03 Treatment Incomplete at Discharge: Individual discharged from a program area without significant progress toward completing treatment goals at discharge or after the CSB lost contact with the individual for 90 days. In the later situation, the TypeOfCareThroughDate is the date of the last face-to-face service or service-related contact.<br>04 Individual Died: Individual's death is documented in his or her clinical record.<br>05 Breaking Program Rules: Individual discharged from a program area for breaking program rules.<br>06 Retired: This code is not available for use by CSBs and is hidden in the extract software. Archival data will be combined with 03 Treatment Incomplete at Discharge. | | | |
| 12 | **Discharge Status:** *(continued)* | Text | 2 |

| No. | Data Element Name and Definition | Data Type | Max Length |
|---|---|---|---|
| Must match one of the values in the lookup table, lkpDisStatus. Valid codes are:<br>07 Other: Includes individuals who moved or left treatment due to illness, hospitalization, transfer to a state training center or certified nursing facility (DD), or for any other reason not captured by a value in the lookup table.<br>08 Individual Incarcerated: Individual discharged due to incarceration in a prison, local or regional jail or juvenile detention center, or other place of secure confinement. This does not include involuntary admission to a state or local psychiatric hospital or unit; in this situation, the individual should continue as an open case at the CSB.<br>96 Not Applicable<br>97 Unknown (Asked but not answered)<br>98 Not Collected (Not asked) | | | |
| **Purposes:** Identify outcomes and meet FBG and TEDS reporting requirements. | | | |
| | | | |
| 13a | **SMI SED At Risk:** Code indicating if the individual has serious mental illness (SMI), serious emotional disturbance (SED), or is at-risk of SED, as defined in the current core services taxonomy. | Text | 2 |
| Must match one of the values in the lookup table, lkpSMISED. Valid codes are:<br>01 None<br>11 Serious Mental Illness (SMI)<br>12 Serious Emotional Disturbance (SED)<br>13 At-risk of SED<br>96 Not Applicable<br>97 Unknown (Asked but not answered)<br>98 Not Collected (Not asked) | | | |
| **Purposes:** Describe levels of disability for individuals receiving services in DBHDS Annual Report and meet MHBG reporting requirements. | | | |
| | | | |
| 14 | **City County Residence Code:** Federal (FIPS) code indicating the city or county in which the individual lives. | Text | 3 |
| Must match one of the values in the lookup table, lkpFIPS. | | | |
| **Purpose:** Map service patterns. | | | |
| 15 | **Referral Source:** The person, agency, or organization that referred the individual **TO** the CSB for evaluation, treatment and/or other services *Admitted or enrolled in program area, 100,200,300.* | Text | 2 |

| No. | Data Element Name and Definition | Data Type | Max Length |
|---|---|---|---|
| | Must match one of the values in the lookup table, lkpReferral. Valid codes are:<br>01 Self<br>02 Family or Friend<br>06 Developmental Disabilities (DD) Provider (Waiver) – DBHDS Licensed<br>07 School System or Educational Authority<br>08 Employer or Employee Assistance Program (EAP)<br>09 ASAP or DUI Program<br>10 Police or Sheriff<br>11 Local Correctional Facility<br>12 State Correctional Facility<br>13 Local Community Probation and Pre-Trial Services<br>~~14 Probation Office~~<br>~~15 Parole Office~~<br>16 Other Community Referral<br>17 Private Hospital<br>~~18 Private Physician~~<br>~~19 Private BH Outpatient Practitioner~~<br>~~20 State BH Outpatient Practitioner~~<br>21 State Hospital*<br>22 State Training Center (ICF/IID certified)- *SEVTC or CVTC*<br>23 ~~Non-Hospital SA Care Provider~~<br>24 Court<br>~~25 Department of Social Services (DSS) ** (other than ALF)~~<br>~~26 Health Department (i.e., local or state level)~~<br>27 Other Virginia CSB/BHA<br>~~28 Department for Aging and Rehabilitative Services(DARS)~~<br>~~29 Department of Social Services TANF Caseworker~~<br>30 Department of Social Services ~~(Not TANF)~~<br>31 Department of Juvenile Justice (DJJ)<br>32 Family Assessment and Planning Team/CSA office<br>33 Residential Substance Abuse Treatment Facility<br>34 Part C Provider *(NOTE: 29 are CSB operated & 11 external partner programs)*<br>35 Nursing Facility (certified) (*includes Hiram Davis Medical Center (HDMC)*<br>36 other BH healthcare provider<br>37 Alcohol or another SA Provider<br>38 Primary Health Care Provider – *All regardless of who provider or operator is (i.e., private and CSB).*<br>39 Specialty Provider/Clinician External *(i.e., neurologist, neurobehavioral psychologist, rheumatologist, dentist, PT, OT, SLP, etc.) not associated with the CSB)*<br>40 Psychiatric Residential Treatment Facility (PRTF) (i.e., *Alice C. Tyler Village, Barry Robinson Center, Bridges Treatment Center, Commonwealth Center for Children and Adolescents, Cumberland Hospital, FairWinds – Horseshoe, Grafton Integrated Health, Hallmark Youthcare- Richmond, Harbor Point Center for BH, Hughes Center, Jackson Field BH, Kempsville Center for BH, Liberty Point BH, North Spring BH, Newport News BH, Phoenix House Counseling, Phoenix House Program, Popular Springs Hospital, Riverside BH, Timber Ridge School, UMFS of VA-Centreville, UMFS – Richmond, Youth for Tomorrow)*<br>41 State Probation and Parole<br>42 Federal Probation<br><br>97 Unknown (Asked but not answered)<br>98 Not Collected (Not asked)<br><br>*Code referrals from Virginia Center for Behavioral Rehabilitation as State Hospital (code 21).<br>**Note: 96 is not a valid code for this data element** | | |
| | **Purposes:** Meet TEDS, MHBG reporting requirements and respond to inquiries about linkages with other agencies, and STEP-VA | | |
| 16 | **Date of Birth:** The date of birth of the individual receiving services. | Text | 8 |

| No. | Data Element Name and Definition | Data Type | Max Length |
|---|---|---|---|
| MMDDYYYY with no spaces, slashes, or special characters. Use two digits for month and day, *e.g.*, February is 02; February 1 is 0201. | | | |
| **Purposes:** Meet FBG, TEDS and STEP – VA reporting requirements and construct unique identifier algorithm for One Source. | | | |
| 17 | **Gender:** The gender of the individual receiving services as identified by the individual. | Text | 2 |
| Must match one of the values in the lookup table, lkpGender. Valid codes are: | | | |
| 01 Female<br>02 Male | 97 Unknown (Asked but not answered)<br>98 Not Collected (Not asked) | | |
| **Purposes:** Meet FBG and TEDS reporting requirements and construct unique identifier algorithm for One Source. | | | |
| 18 | **Race:** The race of the individual receiving services as identified by the individual. | Text | 2 |
| Must match one of the values in the lookup table, lkpRace. Valid codes are: | | | |
| 01 Alaska Native<br>02 American Indian<br>03 Asian or Pacific Islander<br>04 Black or African American<br>05 White<br>06 Other<br>13 Asian<br>23 Native Hawaiian or Other Pacific Islander | 31 American Indian or Alaska Native and White**<br>32 Asian and White**<br>33 Black or African American and White**<br>34 American Indian or Alaska Native and Black or African American**<br>35 Other Multi-Race**<br>97 Unknown (Asked but not answered)<br>98 Not Collected (Not asked)<br>**Note: 96 is not a valid code for this data element.** | | |
| Individuals can self-identify one of these races, used by the federal Office of Management and Budget in the 2000 census: American Indian (02) or Alaska Native (01), Asian (13), Black or African American (04), Native Hawaiian or Other Pacific Islander (23), White (05), or Other (06). Alternately, individuals can choose one of the new multi-race codes, designated with the ** in the table.<br>CCS 2 used code 03 for historical purposes; CSBs must not use this code in CCS 3 for new individuals receiving services. | | | |
| **Purposes:** Meet FBG and TEDS reporting requirement and respond to other inquiries. | | | |

| No. | Data Element Name and Definition | Data Type | Max Length |
|---|---|---|---|
| 19 | **Hispanic Origin:** The Hispanic origin of the individual receiving services as identified by the individual using codes provided by the federal government. | Text | 2 |

Must match one of the values in the lookup table, lkpHispanic. Valid codes are:

01 Puerto Rican
02 Mexican
03 Cuban
04 Other Hispanic
05 Not of Hispanic Origin
06 Hispanic - Specific origin not identified
97 Unknown (Asked but not answered)
98 Not Collected (Not asked)

**Note: 96 is not a valid code for this data element.**

**Purposes:** Meet FBG and TEDS reporting requirements and respond to other inquiries.

| | | | |
|---|---|---|---|
| 21 | **Education Level:** The level of education of the individual receiving services; specifies the highest secondary school, vocational school, or college year completed or attained. There is no separate code for special education. Individuals who are in special education or have graduated from special education should have the highest school grade completed entered. | Text | 2 |
| 21 | **Education Level:** *(continued)* | Text | 2 |

Must match one of the values in the lookup table, lkpEducation. *Italicized language* below further defines the codes. Valid codes are:

01 No Years of Schooling (also use for a child under 3 or 3-4 years old who is not in pre-school)

11 Grade 1
12 Grade 2
13 Grade 3
14 Grade 4
15 Grade 5
16 Grade 6
17 Grade 7
18 Grade 8
19 Grade 9
20 Grade 10
21 Grade 11
22 Grade 12

*Code an individual who has completed a GED as Grade 12.*

23 Nursery, Pre-School, Head Start
24 Kindergarten
25 Special Education *(see note below)*
26 Vocational Only
27 College Undergraduate Freshman
28 College Undergraduate Sophomore
29 College Undergraduate Junior
30 College Undergraduate Senior
31 Graduate or Professional Program
97 Unknown (Asked but not answered)
98 Not Collected (Not asked)

**Note: 96 is not a valid code for this data element.**

***Note:*** *Use Code 25 only for individuals who are in a self-contained, in a special education program without an equivalent school grade level; with mainstreaming, this code should be used rarely. Instead, follow the instruction in the definition on the previous page.*

**Purposes:** Meet FBG and TEDS reporting requirements and respond to other inquiries.

| No. | Data Element Name and Definition | Data Type | Max Length |
|---|---|---|---|
| 22 | **Employment Status:** Code indicating the employment status of the individual receiving services; *e.g.*, employed, unemployed, in an employment program, or not in the labor force; CSBs must collect this at admission to and discharge from a program area and **update it annually**. | Text | 2 |

Must match one of the values in the lookup table, lkpEmployment. *Italicized language* further defines the codes. Select the one code below that most accurately describes the individual's employment status when it is collected. Valid codes are:

Must match one of the values in lkpEmployment. *Italicized language* further defines the codes. Valid codes are:

01 Employed Full Time: Employed 35 hours a week or more; includes Armed Forces *This does not include an individual receiving supported or sheltered employment; the correct code for this individual is 12 or 13.*

02 Employed Part Time: Employed less than 35 hours a week *This does not include an individual receiving supported or sheltered employment; the correct code for this individual is 12 or 13.*

03 Unemployed but Seeking Employment

06 Not in Labor Force: Homemaker *The individual is not in the labor force only because he or she is a homemaker and has no other valid employment status.*

07 Not in Labor Force: Student or Job Training Program *Job training program does not include supported or sheltered employment, but it does include prevocational or day support services.*

08 Not in Labor Force: Retired

09 Not in Labor Force: Disabled *The individual is not in the labor force only because of his or her physical disability, mental illness, developmental disability, or substance use disorder.*

10 Not in Labor Force: Resident or Inmate of Institution *The individual is not in the labor force only because he or she lives in a state or local hospital, training center, nursing home, local or regional jail or state correctional facility, or other institution.*

11 Not in Labor Force-Other: Unemployed and not Seeking Employment *The individual is unemployed and does not want a job or employment, or another value (e.g., 07 student) is not appropriate due to his or her age (e.g., four years old).*

12 Employment Program: Supported Employment *The individual receives individual or group supported employment services, defined in the core services taxonomy or works in a supported employment setting.*

13 Not in Labor Force: Sheltered Employment *The individual receives sheltered employment services, defined in the core services taxonomy, or works in a sheltered employment setting.*

97 Unknown (Asked but not answered) *The individual or his or her authorized representative did not provide an employment status.*

98 Not Collected (Not asked) *This value must not be used for individuals admitted to a program area; its use is only appropriate for individuals for whom a case is opened to receive Emergency or Ancillary Services.*

**Note: 96 is not a valid code for this data element.**

The code selected should be the most meaningful description of the individual's employment status when this data is collected. For example, if the individual at admission is unemployed but wants a job and needs supported employment, the correct value is 03 rather than 12. After the individual is admitted to a program area and is receiving supported employment, the correct value at the annual update is 12.

| No. | Data Element Name and Definition | Data Type | Max Length |
|---|---|---|---|
| **Purposes:** Meet FBG and TEDS reporting requirements, provide DBHDS Annual Report data, and respond to other inquiries. | | | |
| 23 | **Type Of Residence:** Code indicating where the individual receiving services lives. | Text | 2 |
| Must match one of the values in the lookup table, lkpResidence. Valid codes are: | | | |
| 01 Private Residence or Household<br>02 Shelter<br>03 Boarding Home<br>04 Foster Home or Family Sponsor Home<br>05 Licensed Assisted Living Facility (CSB or non-CSB operated)<br>06 Community Residential Service<br>07 Residential Treatment or Alcohol or Drug Rehabilitation (Other Residential Setting)<br>08 Nursing Home or Physical Rehabilitation Facility | 09 Hospital<br>10 Local Jail or Correctional Facility<br>11 State Correctional Facility<br>12 Other Institutional Setting<br>13 None (Homeless or homeless shelter)<br>14 Juvenile Detention Center<br>97 Unknown (Asked but not answered)<br>98 Not Collected (Not asked)<br>**Note: 96 is not a valid code for this data element.** | | |
| **Purposes:** Meet FBG and TEDS reporting requirements, provide DBHDS Annual Report data, and respond to other inquiries (*e.g.*, VHCD). | | | |

| | | | |
|---|---|---|---|
| 24 | **Legal Status:** The legal status of the individual receiving services identifies the type of civil or forensic court order or criminal status related to the individual's admission to a CSB program area or a state facility or to the opening of a record for emergency or ancillary services. | Text | 2 |

Must match one of the values in the lookup table, lkpLegal. Valid codes are:

01 Voluntary: An individual is admitted voluntarily for community (including local inpatient) services or state facility services.
02 Involuntary Civil: An adult is admitted involuntarily, as decided at a non-criminal hearing, for purposes of an NGRI or competency examination or evaluation or for treatment under a Mandatory Outpatient Treatment (MOT) order or an inpatient civil commitment order; this does not include court-ordered psychological evaluations or other assessments for custody cases.
04 Involuntary Juvenile Court: A juvenile is admitted involuntarily, as decided at a non-criminal hearing, for the purposes of an NGRI or competency examination or evaluation or for treatment under an inpatient civil commitment order or remains in the community and is court-ordered to treatment in the community; custody remains with the parent or guardian. This does not include court-ordered psychological evaluations or other assessments for custody cases.
06 Involuntary Criminal: An individual who is incarcerated with pending criminal charges or convictions is admitted involuntarily for evaluation or treatment.
07 Involuntary Criminal Incompetent: An individual who is incarcerated with pending criminal charges is deemed incompetent to stand trial and is admitted involuntarily for competency restoration.
08 Involuntary Criminal NGRI: An individual who has been adjudicated not guilty by reason of insanity (NGRI) is admitted involuntarily for treatment.
09 Involuntary Criminal Sex Offender: An individual who is incarcerated under criminal sex offender charges is admitted involuntarily for evaluation or treatment.
10 Involuntary Criminal Transfer: An individual who is incarcerated with pending criminal charges is transferred to a state hospital from a correctional facility for evaluation or treatment.
11 Treatment Ordered Conditional Release: An individual who has been adjudicated NGRI and released conditionally under a court order.
12 Treatment Ordered Diversion: An individual who has been court-ordered to treatment as a term or condition of diversion from the criminal justice system.
13 Treatment Ordered Probation: An individual who has been court-ordered to treatment as a term or condition of probation.
14 Treatment Ordered Parole: An individual who has been court-ordered to treatment as a term or condition of parole.
97 Unknown (Asked but not answered)
98 Not Collected (Not asked)

**Note:** An individual who is ordered to the CSB for a psychological evaluation or other assessment in connection with a custody case would be recorded as 01 (Voluntary). **Note: 96 is not a valid code for this data element.**

**Purposes:** Meet FBG and TEDS reporting requirements and respond to other inquiries.

| | | | |
|---|---|---|---|
| 25 | **Nbr Prior Episodes Any Drug:** The number of previous episodes of care in which the individual has received any substance use disorder services, regardless of the setting (*e.g.*, hospital, community, another state). This number reflects complete episodes of care since the individual first entered the system. | Text | 2 |

Must match one of the values in the lookup table, lkpEpisodes. Valid codes are:

| | | |
|---|---|---|
| 00 No prior episodes | 03 Three prior episodes | 96 Not Applicable |
| 01 One prior episode | 04 Four prior episodes | 97 Unknown (Asked but not answered) |
| 02 Two prior episodes | 05 Five or more prior episodes | 98 Not Collected (Not asked) |

**Purposes:** Meet TEDS (federal SABG) reporting requirements and respond to other inquiries.

| | | | |
|---|---|---|---|
| 32 | **SAPD Type:** The primary substance use disorder problem (drug of abuse) of the individual receiving services. | Text | 2 |

Must match one of the values in the lookup table, lkpDrug. Valid codes are:

01 None
02 Alcohol
03 Cocaine or Crack Cocaine
04 Marijuana or Hashish: Including THC and other cannabis sativa preparations
05 Heroin
06 Non-prescription Methadone
07 Other Opiates/Synthetics: Including codeine, Dilaudid, morphine, Demerol, opium, and any other drug with morphine-like effects
08 PCP - Phencyclidine
09 Other Hallucinogens: Including LSD, DMT, STP mescaline, psilocybin, or peyote
10 Methamphetamines
11 Other Amphetamines: Including Benzadrine, Dexedrine, Preludin, Ritalin, and any other "…amines" and related drugs
12 Other Stimulants
13 Benzodiazepine: Including Diazepam, Flurazepam, Chlordiazepoxide, Clorazepate, Lorazepam, Alprazolam, Oxazepam, Temazepam, Prazepam, or Triazolam,
14 Other Tranquilizers
15 Barbiturates: Including Phenobarbital, Seconal, or Nembutal
16 Other Sedatives or Hypnotics: Including chloralhydrate, Placidyl, Doriden, or mempromate
17 Inhalants: Including ether, glue, chloroform, nitrous oxide, gasoline, or paint thinner
18 Over the Counter: *e.g.*, aspirin, cough syrup, , over-the-counter diet aids, and any other legally obtained, non-prescription medication.

| | |
|---|---|
| 20 Other | 97 Unknown (Asked but not answered) |
| 96 Not Applicable | 98 Not Collected (Not asked) |

**Purposes:** Meet SABG and TEDS reporting requirements and respond to other inquiries.

| | | | |
|---|---|---|---|
| 33 | **SAPD Freq Use:** The individual's frequency of use of the primary drug of abuse. | Text | 2 |

Must match one of the values in the lookup table, lkpFrequency. *Italicized language* below further defines the codes. Valid codes are:

01 No use in the past month - *an individual has not used any drug in past month or an individual who is not currently a user is seeking service to avoid a relapse*
02 One to three times in the past month
03 One to two times per week
04 Three to six times per week
05 Daily
96 Not Applicable
97 Unknown (Asked but not answered)
98 Not Collected (Not asked)

**Purposes:** Meet SABG and TEDS reporting requirements and respond to other inquiries.

| | | | |
|---|---|---|---|
| 34 | **SAPD Meth Use:** The individual's method of use or usual route of administration for the primary drug of abuse. | Text | 2 |

Must match one of the values in the lookup table, lkpDrugMethod. Valid codes are:

01 Oral
02 Smoking
03 Inhalation
04 Injection (IV or Intramuscular)
05 Other
96 Not Applicable
97 Unknown (Asked but not answered)
98 Not Collected (Not asked)

**Purposes:** Meet FBG and TEDS reporting requirements and respond to other inquiries.

| | | | |
|---|---|---|---|
| 35 | **SAPD Age Use:** The age at which the individual receiving services first used the primary drug of abuse or, for alcohol, the age of the individual's first intoxication. | Text | 2 |

There is no lookup table for this field. The age must not be older than the individual's age. Valid codes are:

00 Newborn
01-95 Actual Age of First Use
96 Not Applicable
97 Unknown
98 Not Collected

**Purposes:** Meet SABG and TEDS reporting requirements and respond to other inquiries.

| | | | |
|---|---|---|---|
| 36 | **SASD Type:** The secondary substance use disorder problem (drug of abuse) of the individual receiving services. | Text | 2 |

Valid codes are the same as the type of the individual's primary drug of abuse.

| | | | |
|---|---|---|---|
| 37 | **SASD Freq Use:** The individual's frequency of use of the secondary drug of abuse. | Text | 2 |

Valid codes are the same as the frequency of use for the individual's primary drug of abuse.

| | | | |
|---|---|---|---|
| 38 | **SASD Meth Use:** The individual's method of use or usual route of administration for the secondary drug of abuse. | Text | 2 |

Valid codes are the same as the method of use for the individual's primary drug of use.

| | | | |
|---|---|---|---|
| 39 | **SASD Age Use:** The age at which the individual receiving services first used the secondary drug of abuse, or for alcohol, the age of the individual's first intoxication. | Text | 2 |

Valid codes are the same as the age at first use for the individual's primary drug of abuse.

| | | | |
|---|---|---|---|
| 40 | **SATD Type:** The tertiary substance use disorder problem (drug of abuse) of the individual receiving services. | Text | 2 |
| Valid codes are the same as for the type of the individual's primary drug of abuse. | | | |
| 41 | **SATD Freq Use:** The individual's frequency of use of the tertiary drug of abuse. | Text | 2 |
| Valid codes are the same as the frequency of use for the individual's primary drug of abuse. | | | |
| 42 | **SATD Meth Use:** The individual's method of use or usual route of administration for the tertiary drug of abuse. | Text | 2 |
| Valid codes are the same as the method of use for the individual's primary drug of use. | | | |
| 43 | **SATD Age Use:** The age at which the individual receiving services first used the tertiary drug of abuse or, for alcohol, the age of the individual's first intoxication. | Text | 2 |
| Valid codes are the same as the age at first use for the individual's primary drug of abuse. | | | |
| 44 | **Pregnant Status:** Indicates if the individual is a female with a substance use disorder who is pregnant | Text | 1 |
| Must match one of the values in the lookup table, lkpYesNo. Gender must be 01 (Female) to enter a 'Y' status. Valid codes are:<br>Y Yes<br>N No<br>U Unknown (Asked but not answered)<br>X Not Collected (Not asked)<br>A Not Applicable | | | |
| **Purposes:** Meet FBG reporting requirements and respond to other inquiries. | | | |
| 45 | **Female With Dependent Children Status:** Indicates if the individual is a female with a substance use disorder who is living with dependent children (ages birth through 17) | Text | 1 |
| Must match one of the values in the lookup table, lkpYesNo. Gender must be 01 (Female) to enter a 'Y' status. Valid codes are:<br>Y Yes<br>N No<br>A Not Applicable<br>U Unknown (Asked but not answered)<br>X Not Collected (Not asked) | | | |
| **Purposes:** Meet FBG reporting requirements and respond to other inquiries. | | | |

| | | | |
|---|---|---|---|
| 47 | **Nbr Of Arrests:** Number of arrests of the individual in the past 30 days preceding admission to the mental health or substance use disorder services program area. CSBs must collect and report this at admission to and discharge from a program area and **annually at the individualized service plan review**. | Text (integer) | 2 |
| Any formal arrest should be counted, regardless of whether incarceration or conviction resulted or regardless of the status of the arrest proceedings on the date of admission. Valid codes are:<br>00-31 Number of arrests<br>96 Not Applicable<br>97 Unknown (Asked but not answered)<br>98 Not Collected (Not asked) | | | |
| **Purposes:** Meet FBG and TEDS reporting requirements and respond to other inquiries. | | | |
| 48 | **Service From Date:** MMDDYYYY indicating the date on which the service occurred or on which the service began within the reporting month for those services spanning more than one day. | Text | 8 |
| Must be a valid date within the current fiscal year, which starts on July 1 of one year and ends on June 30 of the following year. | | | |
| **Purpose:** Meet FBG and TEDS reporting requirements. | | | |
| 57 | **Medicaid Nbr:** The Medicaid number of the individual receiving services in the format specified by the Department of Medical Assistance Services (DMAS), only 12 numeric characters. | Text | 12 |
| Reported for individuals enrolled in Medicaid at their admission to a program area. If an individual is enrolled in Medicaid at one point, but then loses his or her Medicaid eligibility, the value in this field should continue to show the Medicaid number. If the individual's Medicaid number changes, then the new number must be transmitted. If a CSB includes formatting characters (*e.g.*, hyphens, pound signs) in its Medicaid number, the CSB must strip them out before exporting the number to the CCS 3 extract. Do not enter Medicaid HMO, Managed Care, Commonwealth Coordinated Care (Medicare Medicaid Dual Eligible) Project, or Medicaid Governor's Access Plan (GAP) [NOTE: *GAP ended 3/1/19, do not include GAP after 3/1/19]* numbers in this field; reflect these coverages in the InsuranceType data elements (71-78). Enter only actual Medicaid numbers in data element 57. | | | |
| **Purposes:** Collect data for the DBHDS Annual Report and respond to other inquiries. | | | |
| 58 | **Consumer First Name:** The first name of the individual receiving services, used to extract characters for input to a probabilistic matching algorithm run by the Department to generate a unique consumer Id. The full first name is not transmitted to the Department. | Text | 30 |
| Any valid alphanumeric character. | | | |
| **Purpose:** Construct unique identifier algorithm for OneSource. | | | |
| 59 | **Consumer Last Name:** The last name of the individual receiving services, used to extract characters for input to a probabilistic matching algorithm run by the Department to generate a unique consumer Id. The full last name is not transmitted to Department. | Text | 30 |

| | | | |
|---|---|---|---|
| Any valid alphanumeric character. Last names with hyphens should put the individual's legal last name before the hyphen. | | | |
| **Purpose:** Construct unique identifier algorithm for One Source. | | | |
| 60 | **Type Of Care Through Date:** MMDDYYYY indicating the ending date of a type of care. | Text | 8 |
| Must be a valid date and must be the same date as the TypeOfCareFromDate or later. Must not be a date in the future (*e.g.*, past the date of the extract file at the latest). | | | |
| **Purpose:** Meet FBG and TEDS reporting requirements. | | | |
| 61 | **Type Of Care From Date:** MMDDYYYY indicating the starting date of a type of care. | Text | 8 |
| Must be a valid date. Must not be before a previous TypeOfCareThroughDate in the same program area. | | | |
| **Purpose:** Meet FBG and TEDS reporting requirements. | | | |
| 62 | **Service Through Date:** MMDDYYYY indicating the ending date of a service. If the service through date is the same as the ServiceFromDate; i.e. the service started and ended on the same day, this value should be the same as the service from date. | Text | 8 |
| Must be a valid date and must be the same day as the ServiceFromDate or later. Must not be a date in the future (*e.g.*, past the date of the extract file at the latest). | | | |
| **Purpose:** Meet FBG and TEDS reporting requirements. | | | |
| 63 | **Staff Id:** Indicates the local staff identification number. | Text | 10 |
| This is an **optional data element** supplied by CSBs on a **voluntary basis**. If it omits this field, the CSB must represent it with two consecutive commas for formatting NULL values in the extract file (refer to Appendix E). | | | |
| **Purpose:** Provide information for quality improvement and management. | | | |

| | | | |
|---|---|---|---|
| 64 | **Service Subtype:** A specific activity associated with a particular core service category or subcategory for which a Service.txt file is submitted. The core services taxonomy defines Service subtypes only for emergency and two case management services. CSBs must collect service subtype at every emergency service or case management service encounter and report it in the Service file. For developmental case management services only, CSBs must submit a separate service record for each service provided during a month (see page 5). | Text | 2 |

Must match one of the values in the lookup table, lkpServiceSubtype. Valid codes are:

01 Crisis Intervention: Clinical intervention in response to an acute crisis episode; includes counseling, short term crisis counseling, triage, or disposition determination; this includes all emergency services not included in subtypes 02 through 06 below

02 Crisis Intervention Provided Under an ECO: Clinical intervention and evaluation provided by a certified preadmission screening evaluator in response to an emergency custody order (ECO) issued by a magistrate

03 Crisis Intervention Provided Under Law Enforcement Custody (a paperless ECO): Clinical intervention and evaluation provided by a certified preadmission screening evaluator to an individual under custody of a law enforcement officer without a magistrate-issued ECO

04 Independent Examination: An examination provided by a independent examiner who satisfies the requirements in and who conducts the examination in accordance with § 37.2-815 of the Code of Virginia in preparation for a civil commitment hearing

05 Commitment Hearing: Attendance of a certified preadmission screening evaluator at a civil commitment or recommitment hearing conducted pursuant to § 37.2-817 of the Code of Virginia

06 MOT Review Hearing: Attendance at a review hearing conducted pursuant to §§ 37.2-817.1 through 37.2-817.4 of the Code of Virginia for a person under a mandatory outpatient treatment (MOT) order

13 Case Management Services for Quarterly Case Management ISP Review: Services provided by a case manager for a quarterly case management ISP review in a case management service licensed by the Department

14 Case Management Services for Annual Case Management ISP Meeting: Services provided by a case manager for an annual case management ISP meeting in a case management service licensed by the Department

96 Not Applicable

**Unknown (97) and Not Collected (98) are not valid codes for this data element.**

**Use Not Applicable (96) for any service other than emergency services or case management services and for any mental health, developmental, or substance use disorder case management service that does not involve a quarterly case management ISP review or an annual case management ISP meeting.**

CSBs must use codes 13 and 14 for developmental case management services that involve quarterly case management ISP reviews or annual case management ISP meetings, but CSBs also may use these codes for mental health or substance use disorder case management services that involve quarterly case management ISP reviews or annual case management ISP meetings. If they do not use codes 13 and 14 for mental health or substance use disorder case management services, CSBs must use Not Applicable (96).

**Purposes:** Meet Department of Justice (DOJ) Settlement Agreement reporting requirements and respond to BH law reform data requests.

| | | | |
|---|---|---|---|
| 65 | **Service Location:** The location in which the service for which a Service.txt file is submitted was received by or provided to an individual. CSBs must report service location in the Service file for every service in all program areas (100, 200, and 300) and for emergency services or ancillary services (400). CSBs must collect service location at every service encounter. | Text | 2 |

Must match one of the values in the lookup table, lkpServiceLocation. Valid codes are:

01 Consumer Residence: where the individual lives, his or her primary residence; however, if he or she lives in a CSB or CSB-contracted residential facility, then enter 15. *Include PROJECT LINK effective 7/1/2019 and forward for those CSBs providing PROJECT LINK services.*

02 CSB Program Site: the location in which a CSB or its contractor provides services; if this is where the individual lives, enter 15

03 Court: includes general district and juvenile and domestic relations courts, court services units and probation and parole offices

04 Local or Regional Jail: a facility serving adults primarily; not a Department of Corrections facility

05 Local or Regional Juvenile Detention Center: a facility serving juveniles under the age of 18 who have been committed to the facility; not a Learning Center operated by the state

06 Law Enforcement Facility: a location in the community that houses law enforcement officers; includes police stations and sheriffs' offices

07 Non-State Medical Hospital: a medical hospital licensed by but not operated by the state; includes ~~Veterans Administration (VA~~) hospitals and UVA and MCV hospitals

08 Non-State Psychiatric Hospital or Psychiatric Unit in a Non-State Medical Hospital: a psychiatric hospital or unit licensed by but not operated by the state; includes ~~VA hospitals and~~ UVA and MCV, *VHA and MTF facilities (same definitions as in 15 Referral Source)*

09 State Hospital or Training Center: a facility operated by the Department of Behavioral Health and Developmental Services and defined in § 37.2-100 of the Code of Virginia

10 Educational Facility: includes public or private schools, community colleges, colleges, and universities

11 Assisted Living Facility: a facility licensed by the Department of Social Services that provides housing and care for individuals in need of assistance with daily living activities

12 Nursing Home: a facility licensed by the Department of Health that provides services to individuals who require continuing nursing assistance and assistance with activities of daily living [*note: include Virginia Veterans Care Centers (i.e., Sitter Barefoot- Richmond; Salem VA VA NF – Salem, V); excludes HDMC and SWMHI geriatric unit – code HDMC & SWMHI under 09]*

13 Shelter: a community-based facility that provides temporary housing or living space for a brief period of time to individuals who are homeless or in need of temporary sheltering; generally, does not provide any around-the-clock behavioral health or medical care and may or may not provide basic living amenities, but may provide space for meals, personal hygiene, and overnight accommodations

14 Other Community Setting (any location that is used for the provision of services other than those identified in preceding codes)

15 CSB or CSB-Contracted Residential Facility: this does not include CSB-controlled inpatient beds

**Not Applicable (96), Unknown (97), and Not Collected (98) are not valid codes for this data element.**

**Purpose:** Meet DOJ Settlement Agreement and grant reporting requirements. Purposes: Track services to a high visibility population and respond to requests from the General Assembly and Dept. of Veteran Services.

| | | | |
|---|---|---|---|
| 66 | **Military Status:** The current status of an individual receiving services who is serving or has served in a branch of the U.S. military or who is a dependent family member of the individual. **CSBs must collect and report military status at admission to and discharge from a program area, annually, or when it changes and report it in the Consumer file.**<br>*Please add a flag somewhere in your process for the CM/SC to ask:*<br>*Please inquire about military connection by asking: "Have you or a dependent family member served in the United States military?"*<br>*Family member is a **dependent** spouse or child. Armed Forces or National Guard Dependent Family Member: An individual who is the spouse or the dependent child of an individual who is serving on active duty in, is retired from, or has been discharged from the U.S. Army, Army Reserve, Navy, Naval Reserve, Marine Corps, Marine Corps Reserve, Air Force, Air Force Reserve, Coast Guard, Coast Guard Reserve, or National Guard or the U.S. Public Health Service or Merchant Marine.* (If yes =Code 06 below) | Text | 2 |

Must match one of the values in the lookup table, lkpMilitaryStatus. Valid codes are:

01 Armed Forces on Active Duty: An individual who is serving on active duty in the U.S. Army, Navy, Marine Corps, Air Force, or Coast Guard or the U.S. Public Health Service or the U.S. Merchant Marine and could include mobilized members of the Reserve or Guard

02 Armed Forces Reserve: An individual who is serving in a duty status in a unit of the U.S. Army Reserve, Naval Reserve, Marine Corps Reserve, Air Force Reserve, or Coast Guard Reserve, but currently is not mobilized

03 National Guard: An individual who is serving in a duty status in a unit of the National Guard, but currently is not mobilized

04 Armed Forces or National Guard Retired: An individual who is retired, having served on activity duty as a member of the U.S. Army, Army Reserve, Navy, Naval Reserve, Marine Corps, Marine Corps Reserve, Air Force, Air Force Reserve, Coast Guard, Coast Guard Reserve, or National Guard or the U.S. Public Health Service or Merchant Marine

05 Armed Forces or National Guard Discharged: An individual who has been discharged (any type of discharge) from activity duty in the U.S. Army, Army Reserve, Navy, Naval Reserve, Marine Corps, Marine Corps Reserve, Air Force, Air Force Reserve, Coast Guard, Coast Guard Reserve, or National Guard or the U.S. Public Health Service or Merchant Marine

06 Armed Forces or National Guard **Dependent** Family Member: An individual who is the spouse or the dependent child of an individual who is serving on active duty in, is retired from, or has been discharged from the U.S. Army, Army Reserve, Navy, Naval Reserve, Marine Corps, Marine Corps Reserve, Air Force, Air Force Reserve, Coast Guard, Coast Guard Reserve, or National Guard or the U.S. Public Health Service or Merchant Marine

96 Not Applicable (No military status)

97 Unknown (Asked but not answered)

98 Not Collected (Not asked)

**Purposes:** Track services to a high visibility population and respond to requests from the General Assembly and Dept. of Veteran Services.

| | | | |
|---|---|---|---|
| 67 | **Military Service Start Date:** The year in which the individual's most recent active or reserve duty in the U.S. Army, Army Reserve, Navy, Naval Reserve, Marine Corps, Marine Corps Reserve, Air Force, Air Force Reserve, Coast Guard, Coast Guard Reserve, or National Guard or the U.S. Public Health Service or Merchant Marine began. CSBs must collect and report military service start date at admission to and discharge from a program area, annually, or when it changes and report it in the Consumer file. | Text | 4 |
| Enter the year or null. The format for the year is YYYY. *Enter null if code 06 is used for data element 66.* | | | |
| **Purposes:** Track services to a high visibility population and respond to requests from the General Assembly and Dept. of Veteran Services. | | | |
| 68 | **Military Service End Date:** If retired or discharged, the year in which the individual's most recent active or reserve duty in the U.S. Army, Army Reserve, Navy, Naval Reserve, Marine Corps, Marine Corps Reserve, Air Force, Air Force Reserve, Coast Guard, Coast Guard Reserve, or National Guard or the U.S. Public Health Service or Merchant Marine ended. CSBs must collect military service end date at admission to and discharge from a program area, annually, or when it changes and report it in the Consumer file. | Text | 4 |
| Enter the year or null. The format for the year is YYYY. *Enter null if code 06 is used for data element 66.* | | | |
| **Purposes:** Track services to a high visibility population and respond to requests from the General Assembly and Dept. of Veteran Services. | | | |

| | | | |
|---|---|---|---|
| 70 | **Social Connectedness:** The degree to which the individual receiving mental health or substance use disorder services is connected to his environment through types of social contacts that support recovery. This is measured by how often the individual has participated in any of the following activities in the past 30 days: participation in a non-professional, peer-operated organization that is devoted to helping individuals reach or maintain recovery such as Alcoholics Anonymous, Narcotics Anonymous, Secular Organization for Sobriety, Double Trouble in Recovery, or Women for Sobriety; participation in any religious or faith-affiliated recovery self-help groups; or participation in organizations that support recovery other than the organizations described above, including consumer-run mental health programs and Oxford Houses. CSBs must collect social connectedness at admission to and discharge from a program area and **update it annually** at the annual review of the ISP for individuals who have been receiving services in the program area for one year from the date of admission. | Text | 2 |

Must match one of the values in the lookup table, lkpSocialConnectedness. *Italicized language* further defines the codes. Valid codes are:

01 No Participation in the Past Month
02 Participation One to Three Times in the Past Month
03 Participation One to Two Times per Week
04 Participation Three to Six Times per Week
05 Participation Daily
96 Not Applicable - *For admission to or discharge from the developmental services program area or for opening a record for emergency or ancillary services*
97 Unknown (Asked but not answered)
98 Not Collected (Not asked)

**Purpose:** Meet federal SABG NOMS reporting requirements. Project LINK

| | | | |
|---|---|---|---|
| 71 | **Insurance Type 1:** The type of health insurance currently covering the individual receiving services. CSBs must collect this when a record is opened on the individual for emergency or ancillary services or an individual is admitted to a program area and **update it whenever it changes**. *(04 & 06 are health care benefits, an option for eligible Veterans)* | Text | 2 |

Must match one of the values in the lookup table, lkpInsuranceType. *Italicized language* below further defines the codes. Valid codes are:

01 Private Insurance - *includes Blue Cross/Blue Shield/Anthem, non-Medicaid or Medicare HMOs, self-paying employer-offered insurance, or other private insurance*

02 Medicare - *individual is enrolled in Medicare*

03 Medicaid - *individual is enrolled in Medicaid (for individuals in the three Developmental Disability (DD) Waivers, enter 03 for data element 71 and 10 for data element 72)*

04 Veterans Administration – *Health care benefits*

05 Private Pay - *any payment made directly by the individual or a responsible family member or any payment by non-insurance sources, e.g., courts, social services, jails, or schools*

06 Tricare *(formerly known as CHAMPUS) – health care program for uniformed service members, military retirees and their families (dependents).*

07 FAMIS

08 Uninsured - *if the individual is not covered by any health insurance but private payments are received, enter 08 for data element 71 and 05 for data element 72*

09 Other

10 Medicaid Managed Care - *includes Commonwealth Coordinated Care Plus (CCC+)* members in regular Medicaid, (enter 10 for data element 71 and 03 for data element 72)*

11 Medicare Medicaid Dual Eligible - *includes CCC+ dual eligible members (enter 11 for data element 71, 02 for data element 72, and 03 for data element 73*

~~12 Medicaid Governor's Access Plan (GAP) - *enter 12 for data element 71 and 03 for data element 72*~~ *– GAP ENDS 3/31/19 – stop using*

96 Not Applicable - *use this to fill in fields when the individual receiving services has no other insurance coverage after those indicated in previous InsuranceType data elements (e.g., 71 and 72); for example, if the individual is uninsured and 08 has been entered for data element 71, use 96 for data elements 72 through 78*

97 Unknown (Asked but not answered)

98 Not Collected (Not asked)

**CCC+ includes individuals who are: age 65 and older, in nursing facilities, in the Technology Assisted or EDCD Waivers, in the three DD Waivers but only for their acute and primary care services (actual DD Waiver services and case management, support coordination, and transportation services are carved out of CCC+), in Medallion 3 ABD populations, and effective 01/01/2018 receiving mental health rehabilitation (State Plan Option) services under a CCC+ MCO.*

| | | | |
|---|---|---|---|
| **Purposes**: Meet federal MHBG reporting requirements and respond to data requests (*e.g.*, for Medicaid expansion). | | | |
| 72 | **Insurance Type 2:** See data element 71 for definition. See data element 71 for valid codes. | Text | 2 |
| 73 | **Insurance Type 3:** See data element 71 for definition. See data element 71 for valid codes. | Text | 2 |
| 74 | **Insurance Type 4:** See data element 71 for definition. See data element 71 for valid codes. | Text | 2 |
| 75 | **Insurance Type 5:** See data element 71 for definition. See data element 71 for valid codes. | Text | 2 |
| 76 | **Insurance Type 6:** See data element 71 for definition. See data element 71 for valid codes. | Text | 2 |
| 77 | **Insurance Type 7:** See data element 71 for definition. See data element 71 for valid codes. | Text | 2 |
| 78 | **Insurance Type 8:** See data element 71 for definition. See data element 71 for valid codes. | Text | 2 |
| 81 | **Health Well Being Measure:** Identifies the extent to which the individual remains healthy as evidenced by the absence of unplanned hospital admissions; CSBs must collect and report this quarterly **only for individuals receiving Medicaid Developmental Disability (DD) Waiver services**. For other individuals, use code 96. | Text | 2 |

Must match one of the values in the lookup table, lkpGoalMeasure. *Italicized language* below further defines the codes. Valid codes are:

01 Measure Met - *No unplanned hospital admissions occurred during the quarter.*

02 Measure Partially Met - *Unplanned admission(s) occurred or a hospitalization continued and the individual's case management ISP was reviewed and updated as needed during the quarter.*

03 Measure Not Met - *Unplanned admission(s) occurred and the case management ISP was not reviewed and updated as needed during the quarter.*

04 Measure Not in ISP - ***Do not use.***

96 Not Applicable - *Use for all other individuals receiving services.*

97 Unknown (Asked but not answered)

98 Not Collected (Not asked)

**Purpose**: Meet DOJ Settlement Agreement reporting requirements for the eight domains.

| | | | |
|---|---|---|---|
| 82 | **Community Inclusion Measure:** Identifies the extent to which desired community inclusion outcomes in the individual's ISP have been achieved as determined by the individual, the authorized representative if the individual cannot determine this, and the case manager during the quarterly case management ISP review; CSBs must collect and report this quarterly **only for individuals receiving Medicaid DD Waiver services**. This includes opportunities as part of day support, employment, or residential services for education, employment, volunteer, and community inclusion or engagement activities that involve opportunities to develop relationships and interact with people other than paid program staff. This measure includes individuals who receive Medicaid DD Wavier Community Engagement/Community Coaching services, but it also includes individuals who participate in | Text | 2 |
| 82 | **Community Inclusion Measure:** *(continued)* community inclusion activities provided by other services or non-disability specific organizations. For other individuals, use code 96. | Text | 2 |

Must match one of the values in the lookup table, lkpGoalMeasure. *Italicized language* below further defines the codes. Valid codes are:

01 Measure Met - *Community inclusion and engagement activities that involve opportunities to develop relationships and interact with people other than paid program staff were included in the individual's ISP and occurred at the frequency desired by the individual.*

02 Measure Partially Met - *Community inclusion and engagement activities that involve opportunities to develop relationships and interact with people other than paid program staff were included in the individual's ISP but did not occur at the frequency desired by the individual.*

03 Measure Not Met - *Community inclusion and engagement activities that involve opportunities to develop relationships and interact with people other than paid program staff were not included in the individual's ISP.*

04 Measure Not in ISP - ***Do not use.***

96 Not Applicable - *Use for all other individuals receiving services.*

97 Unknown (Asked but not answered)

98 Not Collected (Not asked)

**Purpose**: Meet DOJ Settlement Agreement reporting requirements for the eight domains.

| | | | |
|---|---|---|---|
| 83 | **Choice and Self-Determination Measure:** Identifies the extent to which the individual's desired life choices (*e.g.*, healthcare, home, people to live with, daily schedule, clothing to wear, living area decoration, church to attend, social and recreational activities to participate in) have been included in the individual's ISP and have been implemented as determined by the individual, the authorized representative if the individual cannot determine this, and the case manager during the quarterly case management ISP review; CSBs must collect and report this quarterly **only for individuals receiving Medicaid DD Waiver services**. For other individuals, use code 96. | Text | 2 |

Must match one of the values in the lookup table, lkpGoalMeasure. *Italicized language* below further defines the codes. Valid codes are: (*The individual*)

01 Measure Met - *Played a major role in making most or all of the decisions that affected him or her such as choosing a physician, dentist, or roommate; meal menus; visitors; daily activities; or what to wear.*
02 Measure Partially Met - *Had some input into making the decisions that affected her or him but did not play a major role in making those decisions.*
03 Measure Not Met - *Rarely or never had input into making the decisions that affected him or her.*
04 Measure Not in ISP - ***Do not use.***
96 Not Applicable - *Use for all other individuals receiving services.*
97 Unknown (Asked but not answered)
98 Not Collected (Not asked)

**Purpose:** Meet DOJ Settlement Agreement reporting requirements for the eight domains.

| | | | |
|---|---|---|---|
| 84 | **Living Arrangement Measure:** Identifies the degree to which an individual has maintained his or her chosen living arrangement, including moving from one home of choice to another, as determined by the individual, the authorized representative if the individual cannot determine this, and the case manager during the quarterly case management individual support plan (ISP) review; CSBs must collect and report this quarterly **only for individuals receiving Medicaid DD Waiver services**. For other individuals, use code 96. | Text | 2 |

Must match one of the values in the lookup table, lkpStabilityMeasure. *Italicized language* below further defines the codes. Valid codes are: (*The individual*)

01 Measure Met Maintained - *Maintained his or her chosen living arrangement.*
02 Measure Met Different - *Moved to a different living arrangement of his or her choice.*
03 Measure Not Met Maintained - *Maintained a current living arrangement not of his or her choice.*
04 Measure Not Met Different - *Moved to a different living arrangement not of his or her choice.*
05 Measure Not in ISP - ***Do not use.***
96 Not Applicable - *Use for all other individuals receiving services.*
97 Unknown (Asked but not answered)
98 Not Collected (Not asked)

**Purpose:** Meet DOJ Settlement Agreement reporting requirements for the eight domains.

| No. | Data Element Name and Definition | Data Type | Max Length |
|---|---|---|---|
| 85 | **Day Activity Measure:** Identifies the degree to which the individual has maintained his or her chosen day activities (*e.g.*, full- or part-time integrated employment, integrated supported employment, or community engagement or other integrated day program) as determined by the individual, the authorized representative if the individual cannot determine this, and the case manager during the quarterly case management ISP review; collected and reported quarterly **only for individuals receiving Medicaid DD Waiver services**. For other individuals, use code 96. | Text | 2 |

Must match one of the values in the lookup table, lkpStabilityMeasure. *Italicized language* below further defines the codes. Valid codes are: (*The individual*)

01 Measure Met Maintained - *Maintained his or her chosen day activities.*
02 Measure Met Different - *Engaged in different day activities of his or her choice.*
03 Measure Not Met Maintained Current - *Maintained current day activities not of his or her choice.*
04 Measure Not Met Different - *Engaged in different day activities not of his or her choice.*
05 Measure Not in ISP - *Individual's choice or individual is in school.*
96 Not Applicable - *Use for all other individuals receiving services.*
97 Unknown (Asked but not answered)
98 Not Collected (Not asked)

**Purpose:** Meet DOJ Settlement Agreement reporting requirements for the eight domains.

| | | | |
|---|---|---|---|
| 86 | **School Attendance Status:** Identifies attendance (including home schooling) by all children (3-17 years old) of at least one day during the past three months; CSBs must collect and report this at admission to and discharge from the mental health services program area **and quarterly**. This also includes young adults (18-21 years old) in special education. | Text | 1 |

Must match one of the values in the lookup table, lkpYesNo. *Italicized language* below further defines the codes. Valid codes are:

Y Yes - *In school at least one day in past three months or if reporting period overlaps summer months*
N No - *No school in past three months excluding summer months*
A Not Applicable - *Use for individuals ages 0-2 or 18 or above unless 18-21 in special education and receiving MH services*
U Unknown (Asked but not answered)
X Not Collected (Not asked)

**Purpose:** Meet federal MHBG reporting requirement.

| No. | Data Element Name and Definition | Data Type | Max Length |
|---|---|---|---|
| | Must match one of the values in the lookup table, lkpYesNo. *Italicized language* below further defines the codes. Valid codes are:<br>Y Yes - *Independent living status in a private residence*<br>N No - *Dependent living status in a private residence*<br>A Not Applicable - *Use for all children, for all adults not living in a private residence (01 in data element 23), and for all individuals admitted to the developmental or SUD services program areas.*<br>U Unknown (Asked but not answered) - *Also use when it cannot be determined if an adult is living independently or dependently in a private residence.*<br>X Not Collected (Not asked) | | |
| | **Purpose:** Meet FBG and TEDS reporting requirements. | | |
| 88 | **Housing Stability:** Identifies the number of changes in residence during a quarter by individuals admitted to the mental health or substance use disorder services program area and receiving mental health or substance use disorder case management services. CSBs must collect this at admission to and discharge from the program area and at each quarterly case management ISP review and report it in the Consumer file. | Text | 2 |
| | Must match one of the values in the lookup table, lkpHousingMoves. *Italicized language* below further defines the codes. Valid codes are:<br>00-95 Number of moves in the last quarter<br>96 Not Applicable - *Use for all individuals not receiving mental health or substance use disorder case management services or for individuals who are homeless.*<br>97 Unknown (Asked but not answered)<br>98 Not Collected (Not asked) | | |
| | **Purpose:** Meet federal MHBG reporting requirement. | | |
| 89 | **Preferred Language:** Identifies the preferred language used by the individual receiving services; CSBS must collect this at admission to the mental health, developmental, or substance use disorder services program area and report it in the Consumer file. | Text | 2 |
| | Must match one of the values in the lookup table, lkpLanguage. Valid codes are:<br>01 English<br>02 Amharic *(Ethiopian)*<br>03 Arabic<br>04 Chinese *(Mandarin/Cantonese/Formosan)*<br>05 Farsi/Persian/Dari<br>06 Hindi<br>07 Japanese<br>08 Korean<br>09 Russian<br>10 Spanish<br>11 Tagalog *(Filipino)*<br>12 Urdu<br>13 Vietnamese<br>14 American Sign Language<br>15 Other Language<br>16 Non-Verbal<br>97 Unknown<br>98 Not Collected | | |
| | **Purposes:** Meet federal standards for Culturally And Linguistically Appropriate Services and promote cultural and linguistic competency. | | |

| No. | Data Element Name and Definition | Data Type | Max Length |
|---|---|---|---|
| Must match one of the values in the lookup table, lkpEmployDiscuss. *Italicized language* below further defines the codes. Valid codes are:<br>01 Employment discussion occurred, individual is employed full or part-time but not in supported employment.<br>02 Employment discussion occurred, individual is receiving supported employment services.<br>03 Employment discussion occurred, individual indicated he or she is not employed and wants to work.<br>04 Employment discussion occurred, individual indicated he or she is not employed and does not want to work.<br>05 Employment discussion did not occur during annual case management ISP meeting.<br>06 Not Applicable - *Use only for any child (age 0 through 17) or for any adult who is not receiving developmental case management services.**<br>98 Not Collected - *Use for any adult who is receiving developmental case management services but whose ISP meeting did not occur during this reporting period. * Data element 91 is not required for MH or SUD case management services; it can be used, but its use is optional.* | | | |
| **Purpose:** Meet DOJ Settlement Agreement reporting and State Board Employment First Policy 1044 (SYS) 12-1 requirements. | | | |
| 92 | **Employment Outcomes:** Identifies an adult (age 18 or older) receiving case management services from the CSB whose case management individualized services and supports plan (ISP), developed or updated at the annual ISP meeting, contains employment outcomes, including outcomes that address barriers to employment. Employment outcomes do not include sheltered employment or prevocational services. | Text | 1 |
| Must match one of the values in the lookup table, lkpYesNoECM. *Italicized language* below further defines the codes. Valid codes are:<br>Y Yes - *ISP contains employment outcomes.*<br>N No - *ISP does not contain employment outcomes.*<br>A Not Applicable - *Use only for any child (age 0 through 17) or for any adult who is not receiving developmental case management services.**<br>X Not Collected - *Use for any adult who is receiving developmental case management services but whose ISP meeting did not occur during this reporting period.*<br>** Data element 92 is not required for MH or SUD case management services; it can be used, but its use is optional.* | | | |
| **Purposes:** Meet DOJ Settlement Agreement reporting and State Board Employment First Policy 1044 (SYS) 12-1 requirements. | | | |
| 93 | **Reported Diagnosis Code:** The current ICD-10 diagnosis of the individual receiving services as determined by clinical staff qualified to make such assessments or reported to CSB staff (*e.g.*, case managers) by other, non-CSB clinical staff qualified to make such assessments. | Text | 7 |
| Valid codes are any ICD-10 diagnosis code without the decimal point. If an individual has no diagnosis yet, a Diagnosis record is not required. However, if a CSB decides to submit a Diagnosis record when an individual has not been evaluated and the diagnosis is still undetermined, 99997 or 99998 will be accepted. | | | |
| **Purpose:** Meet federal MHBG and SABG reporting requirements and report outcome measures adopted by the Department and the VACSB. | | | |

| No. | Data Element Name and Definition | Data Type | Max Length |
|---|---|---|---|
| MMDDYYYY with no spaces, slashes, or special characters. Use two digits for month and day, *e.g.*, February is 02; February 1 is 0201. This must be a valid date. | | | |
| **Purpose:** Meet federal MHBG and SABG reporting requirements and report outcome measures adopted by the Department and the VACSB. | | | |
| 95 | **Diagnosis End Date:** The date the diagnosis ended. | Text | 8 |
| MMDDYYYY with no spaces, slashes, or special characters. Use two digits for month and day, *e.g.*, February is 02; February 1 is 0201. This must be a valid date. | | | |
| **Purpose:** Meet federal MHBG and SABG reporting requirements. | | | |
| 96 | **Discussion of Last Complete Physical Examination:** The case manager asked about the last complete physical examination during discussion with the individual and the authorized representative, if one has been appointed or designated, at his or her most recent annual case management individual support plan (ISP) meeting. CSBs must collect and report this annually **for individuals receiving Medicaid DD Waiver services.** | Text | 1 |
| Must match one of the values in the lookup table, lkpYesNoECM. *Italicized language* below further defines the codes. Valid codes are:<br>Y Yes - *Asked the individual about the physical examination.*<br>N No - *Did not ask the individual about the physical examination.*<br>A Not Applicable - *Use only for any individual who is not receiving Medicaid DD Waiver services.*<br>X Not Collected - *Use only for any individual who is receiving Medicaid DD Waiver services but whose annual ISP meeting did not occur during the reporting period.* | | | |
| **Purpose:** Meet DOJ Settlement Agreement reporting requirements for the eight domains. | | | |
| 97 | **Date of Last Complete Physical Examination:** The date on which an individual received his or her last regularly scheduled complete wellness and preventative physical examination by a medical doctor, physician assistant, or nurse practitioner. This is not a date on which the individual was seen only in response to an illness, medical condition, or injury. The case manager must collect and report this **for individuals of any age receiving DD Waiver services** and **for adults with SMI receiving MH case management services** whenever the date changes. If the exact date is not available or known, an estimated complete date (MMDDYYYY) is acceptable. | Text | 8 |
| MMDDYYYY with no spaces, slashes, or special characters. Use two digits for the month and day, *e.g.*, February is 02 and February 1 is 0201. Must be a valid calendar date and must not be a date in the future (*e.g.*, after the date of the extract file). For all other individuals not receiving DD Waiver services or with SMI receiving MH case management services, this field should be null, unless the CSB chooses to complete this data element for those other individuals. | | | |
| **Purpose:** Meet DOJ Settlement Agreement eight domains reporting requirements and report Department, VACSB outcome measures | | | |

| No. | Data Element Name and Definition | Data Type | Max Length |
|---|---|---|---|
| Must match one of the values in the lookup table, lkpYesNoECM. *Italicized language* below further defines the codes. Valid codes are:<br>Y Yes - *Asked the individual about the dental examination.*<br>N No - *Did not ask the individual about the dental examination.*<br>A Not Applicable - *Use only for any individual who is not receiving Medicaid DD Waiver Services.*<br>X Not Collected - *Use only for any individual who is receiving Medicaid DD Waiver services but whose annual ISP meeting did not occur during the reporting period.* | | | |
| **Purpose:** Meet DOJ Settlement Agreement eight domains reporting requirements. | | | |
| 99 | **Date of Last Scheduled Dental Examination:** The date on which an individual received his or her last regularly scheduled routine preventative dental examination by a dentist. This is not a date on which the individual was seen only for a routine tooth cleaning without an examination by a dentist or for a dental emergency. The case manager must collect and report this date whenever it changes **for individuals of any age receiving Medicaid DD Waiver services.** If the exact date is not available or known, an estimated complete date (MMDDYYYY) is acceptable. | Text | 8 |
| MMDDYYYY with no spaces, slashes, or special characters. Use two digits for the month and day, *e.g.*, February is 02 and February 1 is 0201. Must be a valid calendar date and must not be a date in the future (*e.g.*, after the date of the extract file). For all other individuals not receiving Medicaid DD Waiver services, this field should be null, unless the CSB chooses to complete this data element for those other individuals. | | | |
| **Purpose:** Meet DOJ Settlement Agreement eight domains reporting requirements. | | | |

| No. | Data Element Name and Definition | Data Type | Max Length |
|---|---|---|---|
| Must match one of the values in the lookup table, lkpYesNo. *Italicized language* below further defines the codes. Valid codes are:<br>Y Yes - *Discussion occurred about Medicaid DD Waiver Community Engagement/ Community Coaching services*<br>N No - *Discussion about Medicaid DD Waiver Community Engagement/ Community Coaching services did not occur during the annual case management ISP meeting.*<br>A Not Applicable - *Use only for any individual who is not receiving Medicaid DD Waiver services.*<br>U Unknown (Asked but not answered)<br>X Not Collected (Not asked) - *Use for any individual who is receiving Medicaid DD Waiver services but whose annual ISP meeting did not occur during the reporting period.* | | | |
| **Purpose:** Meet DOJ Settlement Agreement reporting requirements for the eight domains. | | | |
| 101 | **Community Engagement/~~or~~ Community Coaching Services Goals:** Identifies an individual receiving case management services from the CSB whose case management individualized services and supports plan (ISP), developed or updated at the annual ISP meeting, contained Medicaid DD Waiver Community Engagement/~~or~~ Community Coaching services goals. CSBs must collect and report this **only for individuals receiving Medicaid DD Waiver services**. For others, use code A. | Text | 1 |
| Must match one of the values in the lookup table, lkpYesNo. *Italicized language* below further defines the codes. Valid codes are:<br>Y Yes - *ISP contains Medicaid DD Waiver Community Engagement/~~or~~ Community Coaching services goals.*<br>N No - *ISP does not contain Medicaid DD Waiver Community Engagement/ Community Coaching services goals.*<br>A Not Applicable - *Use only for any individual who is not receiving Medicaid DD Waiver services.*<br>U Unknown (Asked but not answered)<br>X Not Collected (Not asked) - *Use for any individual who is receiving Medicaid DD Waiver services but whose annual ISP meeting did not occur during the reporting period.* | | | |
| **Purpose:** Meet DOJ Settlement Agreement reporting requirements for the eight domains. | | | |

| | | | |
|---|---|---|---|
| 102 | **Date of Assessment:** MMDDYYYY indicating the date on which the assessment used for the outcome occurred. | Text | 8 |

Must be a valid date within the current fiscal year, which starts on July 1 of one year and ends on June 30 of the following year.

**Purpose:** Report outcome measures adopted by the Department and the VACSB, including Same Day Access (SDA), and STEP-VA

| | | | |
|---|---|---|---|
| 103 | **Assessment Action:** The type of assessment or action related to the assessment for the outcome measure. | Text | 2 |

Must match one of the values in the lookup table, lkpOutcomeAction. *Italicized language* below further defines the codes. Valid codes are:

01 Columbia Suicide Severity Rating Scale, Screener Version
02 Body Mass Index (BMI) Assessment
03 BMI Follow Up Documented
04 Patient Health Questionnaire - 9 (PHQ-9)
05 Same Day Access (SDA) Assessment - *an individual receives a clinical behavioral health assessment, not just a screening, from a licensed or license-eligible clinician when he or she requests mental health or substance use disorder services. This does not include other assessments such as psychological or competency evaluations. When data element 103 is coded 05, code data element 104 as 01 if the assessment determined the individual needed services or 02 if it did not; in either case, code data element 105 as 96.*
06 First Available Appointment Offered - *Based on the SDA assessment, if applicable, an individual is offered an appointment in a mental health or substance use disorder service offered at the CSB that best meets his or her needs. When data element 103 is coded 06, code data element 104 as 00 and element 105 as 96 and enter the date in data element 107*

*Other codes can be added for new outcome assessments or actions.*

07 Primary Care Screening *a yearly primary care screening to include, at minimum, height, weight, blood pressure, and BMI.*
08 Anti-psychotic medications prescribed by CSB practitioner *(for age 3 and up)*
09 Metabolic Syndrome Screening – *Annual– Glucose,- hemoglobin- lipid profiles*

10 Referral to primary care physician *(Use 01=Yes; 02 – No; 05 = individual/parent/legal guardian refused), for all other physicians other than primary care physicians use code 13; Referral Destinations –lkpReferralDestination use 13*
11 *Individual Attended PCP Appointment follow referral outside normal range (05 Individual/legal guardian refused)*
12 DLA -20 *enter AVERAGE* composite score
13 Referral Destination (other than primary care physicians) *use lkpRreferralDestination in Appendix J*

**Not Applicable (96), Unknown (97), and Not Collected (98) are not valid codes for this data element.** If there is no outcome assessment or action, there would be no outcome record reported.

**Purpose:** Report outcome measures adopted by the Department and the VACSB, including SDA, and STEP-VA

| | | | |
|---|---|---|---|
| 104 | **Assessment Value:** The numeric value of the assessment. | Text | 5 |

Must be consistent with a value in the applicable outcome assessment (*e.g.*, BMI or PHQ-9); use leading zeros to complete the field.

00 None
01 Yes
02 No

| If field 103 is: | Then field 104 must be one of the values before |
|---|---|
| 07 Primary Care Screening Done | 02 No<br>03 Yes, screening values not within normal ranges<br>04 Yes, screening values within normal ranges;<br>05 05 No, legal guardian or individual refused |
| 08 Antipsychotic Medication Use | 01 Yes<br>02 No |
| 09 Metabolic Syndrome Screening | 02 No<br>03 Yes, screening values not within normal ranges<br>04 Yes, screening values within normal ranges;<br>05 No, individual/legal guardian refused |
| 10 Referred to Primary Care Physician (PCP) | 01 Yes<br>02 No<br>05 No, individual/legal guardian referred |
| 11 Individual Attended PCP Appointment | 01 Yes<br>02 No<br>05 No, individual/legal guardian refused |
| 12 DLA -20 Average Composite Score *(technical note only pad with zeros)* | 1.0-7.0 |
| 13 Referral Destination | Use value from Data Element lkpreferraldestination (see Appendix J) |

00 - 27 PHQ-9 Score - *the two-character numeric PHQ-9 score*

00.0-99.9 - BMI Assessment Score - *the three-character numeric BMI score including the decimal point;*

**Not Applicable (96), Unknown (97), and Not Collected (98) are not valid codes for this data element.** See data element 103.

**Purpose:** Report outcome measures adopted by the Department, the VACSB. STEP-VA.

| | | | |
|---|---|---|---|
| 105 | **Assessment Frequency:** The frequency of the outcome assessment or action. | Text | 2 |

| | | | |
|---|---|---|---|
| Must match one of the values in the lookup table, lkpOutcomeFreq. Valid codes are: | | | |
| 01 Initial<br>02 Monthly<br>03 Quarterly<br>04 Annual<br>05 Discharge<br>06 Other<br>96 Not Applicable - *Use when frequency is not applicable.*<br>**Unknown (97), and Not Collected (98) are not valid codes for this data element.** | | | |
| **Purpose:** Report outcome measures adopted by the Department and the VACSB, STEP-VA; DLA -20 | | | |
| 106 | **Service Modality:** This identifies how a service with a service hour unit of service (core service codes 100, 310, 312, 313, 318, 320, 335, 350, 390, 460, 581,610, 620, and 720) is delivered: face-to-face or non-face-to-face. CSBs must report service modality for all services with a service hour unit of service. | Text | 2 |
| Must match one of the values in the lookup table lkpServiceMod. Valid codes are:<br>01 Face-to-Face Service - *staff deliver the service to the individual face-to-face.*<br>02 Non-Face-to-Face Service - *staff provide the service for the individual but not ~~non-~~face-to-face with her or him. For 610 Prevention Services, do not report substance use disorder prevention or Mental Health First Aid or suicide prevention service hours in CCS 3; CSBs report these service units in the Department's separate prevention data system. CSBs must report all mental health and develop mental prevention service hours as 02 since they are reported using the z-consumer function (see page 22 of Core Services Taxonomy 7.3).*<br>96 Not Applicable - *use for any core service with a service unit of a bed day, day of service, or day support hour.*<br>**Unknown (97) and Not Collected (98) are not valid codes for this data element.** | | | |
| **Purpose:** Report outcome measures adopted by the Department and the VACSB, including SDA. | | | |
| 107 | **Related Date:** A date related to an outcome measure. MMDDYYYY indicating the date on which an event related to an outcome occurred. *Currently, CSBs should use this data element only when data element 103 is coded 06 for First Available Appointment Offered; otherwise, leave this field blank (NULL).* | Text | 8 |
| Must be a valid date. | | | |
| **Purpose:** Report outcome measures adopted by the Department and the VACSB, including SDA. | | | |
| 108 | **Transaction ID:** A number that uniquely identifies each record in each service, type of care, diagnosis, or outcomes file in each CCS submission; this is not a data element for Consumer records. | Text | 12 |
| Must be all numeric characters; use leading zeros to complete the field. | | | |
| **Purpose:** Used to track records from individual CSBs in the Department's OneSource data warehouse for data quality purposes. | | | |

| | | | |
|---|---|---|---|
| 109 | **Medicare Beneficiary Identifier (MBI):** The Medicare number for the individual in services from the 2018 Medicare Beneficiary Card (*NOTE: use the Medicare number on the cards distributed in 2018, not the old red, white and blue cards with the beneficiary's SSN #).* | Text | 11 |
| | Reported for individuals enrolled in Medicare at admission to a program area. Enter only actual Medicare numbers in data element. Medicare Beneficiary Identifier (MBI) from the unique identifier Medicare card at admission. Use the 2018 MBI card, do not use the Social Security Number. The MBI must contain only numbers, it must not contain any separation, dashes or other special characters. New Medicare # Sample*: xxxx-xxx-xxxx (4 numbers, 3 numbers, 4 numbers)*<br>(this Not a fatal error ) | | |
| | **Purpose:** Cross validation of records for data reliability, validity and trustworthiness. The MBI uniquely identifies the individual, the data element is to be used to relate the products, services and demographics to someone in our care in order to improve their quality of service/life/outcomes. | | |

The preceding table displays data elements in numerical sequence. However, some data element numbers are missing in that sequential listing because the associated data elements have been discontinued. The following table lists discontinued CCS 2 and CCS 3 data elements.

| No. | Data Element | No. | Data Element | No. | Data Element |
|---|---|---|---|---|---|
| 1 | Transaction Activity Code | 29 | Axis II Secondary | 55 | Axis I Code 6 |
| 4 | CSB Admission Date | 30 | Axis III | 56 | Consumer Service Hours |
| 6 | Service Enrollment Date | 31 | Axis V | 69 | Marital Status |
| 9 | Service Release Date | 46 | Days Waiting to Enter Treatment | 79 | Date Need for MH Services |
| 11 | CSB Discharge Date | 49 | Authorized Representative | 80 | Date Need for SUD Services |
| 13.b | Cognitive Delay | 50 | Medicaid Status | 90 | ECM Case Management |
| 20 | Co-Dependent | 51 | Date of Last Direct SA Service | | |
| 26 | Axis I Code 1 | 52 | Axis I Code 3 | | |
| 27 | Axis I Code 2 | 53 | Axis I Code 4 | | |
| 28 | Axis II Primary | 54 | Axis I Code 5 | | |

# Appendix D: Data Collection Matrix

## When is Data Collected?

In CCS 3, data elements are collected at different steps of the individual's involvement with the CSB. There are two major steps from the standpoint of data extracts:

- Case Opening, and
- Type of Care event, for example, at admission to or at discharge from a program area.

Many data elements also must be **updated whenever they change or at least annually**.

## Case Opening

This step occurs when a CSB determines that it can serve an individual, and it opens a case for the individual. This step requires submission of some of the data elements in the Consumer File table and all of the data elements in the Services file table (Appendix B), but it does not require submission of the event itself in a TypeOfCare file. CSBs must collect the data elements listed in the following table at case opening, although other elements may be collected. A CSB opens a case when it provides emergency or ancillary services (motivational treatment, consumer monitoring, assessment and evaluation, or early intervention services); then the CSB must collect these data elements.

| CCS 3 Data Elements Collected at Case Opening | | | |
|---|---|---|---|
| **No.** | **Data Element** | **No.** | **Data Element** |
| 2 | AgencyCode | 62 | ServiceThroughDate |
| 3 | ProgramAreaId, use only 400 to indicate the service is an emergency or ancillary service | 64 | Service Subtype |
| | | 65 | Service Location |
| 5 | ServiceCode | 71 | InsuranceType1 |
| 7 | ConsumerId (CSB identifier) | 72 | InsuranceType2 |
| 8 | SSN | 73 | InsuranceType3 |
| 10 | Units | 74 | InsuranceType4 |
| 14 | CityCountyResidenceCode | 75 | InsuranceType5 |
| 15 | Referral Source | 76 | InsuranceType6 |
| 16 | DateOfBirth | 77 | InsuranceType7 |
| 17 | Gender | 78 | InsuranceType8 |
| 18 | Race | 93 | ReportedDiagnosisCode |
| 19 | HispanicOrigin | 94 | DiagnosisStartDate |
| 24 | LegalStatus | 106 | Service Modality |
| 44 | PregnantStatus | 108 | Transaction ID |
| 48 | ServiceFromDate | 109 | Medicare Beneficiary Identifier Number |
| 58 | ConsumerFirstName | | |
| 59 | ConsumerLastName | | |

**Admission to or Discharge from a Program Area (Type of Care event)**
When an individual is admitted to or discharged from a program area, a CSB must continue to report and update when necessary the data elements from the case opening step, and it must collect and report the following additional *italicized* data elements.

| CCS 3 Data Elements Collected at Admission To or Discharge From a Program Area | | | |
|---|---|---|---|
| **No.** | **Data Element** | **No.** | **Data Element** |
| 2 | AgencyCode | *70* | *SocialConnectedness* |
| 3 | ProgramAreaId (100, 200, or 300) | 71 | InsuranceType1 |
| 5 | ServiceCode | 72 | InsuranceType2 |
| 7 | ConsumerId (CSB identifier) | 73 | InsuranceType3 |
| 8 | SSN | 74 | InsuranceType4 |
| 10 | Units | 75 | InsuranceType5 |
| *12* | *DischargeStatus* | 76 | InsuranceType6 |
| *13a* | *SMISEDAtRisk* | 77 | InsuranceType7 |
| 14 | CityCountyResidenceCode | 78 | InsuranceType8 |
| *15* | *ReferralSource* | *81* | *HealthWellBeingMeasure* |
| 16 | DateOfBirth | *82* | *CommunityInclusionMeasure* |
| 17 | Gender | *83* | *ChoiceandSelf-DeterminationMeasure* |
| 18 | Race | *84* | *LivingArrangementMeasure* |
| 19 | HispanicOrigin | *85* | *DayActivityMeasure* |
| *21* | *EducationLevel* | *86* | *SchoolAttendanceStatus* |
| *22* | *EmploymentStatus* | *87* | *IndependentLivingStatus* |
| *23* | *TypeOfResidence* | *88* | *HousingStability* |
| 24 | LegalStatus | *89* | *PreferredLanguage* |
| *25* | *NbrPriorEpisodesAnyDrug* | *91* | *EmploymentDiscussion* |
| *32-43* | *SA Primary, Secondary, and Tertiary Drug* | *92* | *EmploymentOutcomes* |
| 44 | PregnantStatus | 93 | ReportedDiagnosisCode |
| *45* | *FemaleWithDependentChildrenStatus* | 94 | DiagnosisStartDate |
| *47* | *NbrOfArrests* | *95* | *DiagnosisEndDate* |
| 48 | ServiceFromDate | *96* | *DiscussionofLastCompletePhysical* |
| *57* | *MedicaidNbr* | *97* | *DateofLastCompletePhysicalExam* |
| 58 | ConsumerFirstName | *98* | *DiscussionofLastScheduledDental* |
| 59 | ConsumerLastName | *99* | *DateofLastScheduledDentalExam* |
| *60* | *TypeOfCareThroughDate* | *100* | *Community Engagement Discussion* |
| *61* | *TypeOfCareFromDate* | *101* | *Community Engagement Goals* |
| 62 | ServiceThroughDate | *102* | *Date of Assessment* |
| *63* | *StaffId (optional)* | *103* | *Assessment Action* |
| 64 | ServiceSubtype | *104* | *Assessment Value* |
| 65 | ServiceLocation | *105* | *Assessment Frequency* |
| *66* | *MilitaryStatus* | *106* | *Service Modality* |
| *67* | *MilitaryStatusStartDate* | *107* | *Related Date* |
| *68* | *MiltaryStatusEndDate* | *108* | *Transaction ID* |

**Data Element and Program Area Cross-Reference Table**

Different data elements apply to and are collected for different program areas, as shown in the following table. Data elements that are collected for emergency or ancillary services are listed in the **CCS 3 Data Elements Collected at Case Opening** table on page 51.

| Data Element and Program Area Cross-Reference Table | | | | |
|---|---|---|---|---|
| **Element No.** | **Data Element** | **Mental Health** | **Substance Use Disorder** | **Develop-mental** |
| 2 | AgencyCode | Y | Y | Y |
| 3 | ProgramAreaId | Y | Y | Y |
| 5 | ServiceCode | Y | Y | Y |
| 7 | ConsumerId (CSB identifier) | Y | Y | Y |
| 8 | SSN | Y | Y | Y |
| 10 | Units | Y | Y | Y |
| 12 | DischargeStatus | Y | Y | Y |
| 13a | SMISEDAtRisk | Y | Y | N |
| 14 | CityCountyResidenceCode | Y | Y | Y |
| 15 | ReferralSource | Y | Y | Y |
| 16 | DateOfBirth | Y | Y | Y |
| 17 | Gender | Y | Y | Y |
| 18 | Race | Y | Y | Y |
| 19 | HispanicOrigin | Y | Y | Y |
| 21 | EducationLevel | Y | Y | Y |
| 22 | EmploymentStatus | Y | Y | Y |
| 23 | TypeOfResidence | Y | Y | Y |
| 24 | LegalStatus | Y | Y | Y |
| 25 | NbrPriorEpisodesAnyDrug | Y | Y | N |
| 32-43 | SA Primary, Secondary, and Tertiary Drug | Y | Y | N |
| 44 | PregnantStatus | Y | Y | N |
| 45 | FemaleWithDependentChildrenStatus | N | Y | N |
| 47 | NbrOfArrests | Y | Y | N |
| 48 | ServiceFromDate | Y | Y | Y |
| 57 | MedicaidNbr | Y | Y | Y |
| 58 | ConsumerFirstName | Y | Y | Y |
| 59 | ConsumerLastName | Y | Y | Y |
| 60 | TypeOfCareThroughDate | Y | Y | Y |
| 61 | TypeOfCareFromDate | Y | Y | Y |
| 62 | ServiceThroughDate | Y | Y | Y |
| 63 | StaffId (**optional**) | Y | Y | Y |
| 64 | ServiceSubtype | Y | Y | Y |
| 65 | ServiceLocation | Y | Y | Y |
| 66 | MilitaryStatus | Y | Y | Y |
| 67 | MilitaryServiceStartDate | Y | Y | Y |
| 68 | MilitaryServiceEndDate | Y | Y | Y |
| 70 | SocialConnectedness | Y | Y | N |
| 71 | InsuranceType1 | Y | Y | Y |

| Data Element and Program Area Cross-Reference Table | | | | |
|---|---|---|---|---|
| **Element No.** | **Data Element** | **Mental Health** | **Substance Use Disorder** | **Develop-mental** |
| 72 | InsuranceType2 | Y | Y | Y |
| 73 | InsuranceType3 | Y | Y | Y |
| 74 | InsuranceType4 | Y | Y | Y |
| 75 | InsuranceType5 | Y | Y | Y |
| 76 | InsuranceType6 | Y | Y | Y |
| 77 | InsuranceType7 | Y | Y | Y |
| 78 | InsuranceType8 | Y | Y | Y |
| 81 | HealthWellBeingMeasure | N | N | Y |
| 82 | CommunityInclusionMeasure | N | N | Y |
| 83 | ChoiceandSelf-DeterminationMeasure | N | N | Y |
| 84 | LivingArrangementMeasure | N | N | Y |
| 85 | DayActivityMeasure | N | N | Y |
| 86 | SchoolAttendanceStatus | Y | N | N |
| 87 | IndependentLivingStatus | Y | N | N |
| 88 | HousingStability | Y | Y | N |
| 89 | PreferredLanguage | Y | Y | Y |
| 91 | EmploymentDiscussion | Y* | Y* | Y |
| 92 | EmploymentGoals | Y* | Y* | Y |
| 93 | ReportedDiagnosisCode | Y | Y | Y |
| 94 | DiagnosisStartDate | Y | Y | Y |
| 95 | DiagnosisEndDate | Y | Y | Y |
| 96 | DiscussionofLastCompletePhysicalExam | N | N | Y |
| 97 | DateofLastCompletePhysicalExamination | Y | N | Y |
| 98 | DiscussionofLastScheduledDentalExam | N | N | Y |
| 99 | DateofLastScheduledDentalExamination | N | N | Y |
| 100 | Community Engagement Services Discussion | N | N | Y |
| 101 | Community Engagement Services Goals | N | N | Y |
| 102 | Date of Assessment | Y | Y | N |
| 103 | Assessment Action | Y | Y | N |
| 104 | Assessment Value | Y | Y | N |
| 105 | Assessment Frequency | Y | Y | N |
| 106 | Service Modality | Y | Y | Y |
| 107 | Related Date | Y | Y | N |
| 108 | Transaction ID | Y | Y | Y |
| 109 | Medicare Beneficiary Identifier (MBI) number | Y | Y | Y |

* Collecting these data elements is optional per the definitions of data elements 91 and 92.

# Appendix E: Business Rules

Business rules enforce the policies and procedures specified by an organization for its processes. The complete set of current CCS Business Rules is incorporated by reference into these Extract Specifications, and they are contained in the current release of the CCS 3 application. These rules establish acceptable parameters and validation criteria for CCS 3 data elements and describe error-checking routines and operations. CSB staff and IT vendors responsible for implementing CCS 3 should review and must adhere to these business rules.

The following are general business rules for the CCS 3 database not discussed elsewhere in this document. Validation checks are basic business rules, and some of the general validations of CCS 3 data are described below.

**Extract Record Values**

**General**

CSBs must validate all field values in CCS 3 extract files before they submit their extracts to the Department. Invalid data fields will produce fatal errors that will cause a record in a file to be rejected.

**Dates**

All dates must be valid and must be entered in the format MMDDYYYY with no slashes, spaces, or special characters. Leading zeroes must be supplied for single digit days and months, *e.g.*, February 1 is 0201. Century values must be greater than or equal to 1900. There must not be a month value greater than 12, and there must not be a day value greater than 31.

## CCS 3 Unknown Value Codes

The CCS 3 Extract Specifications, in an attempt to improve the data quality of extracts, clarifies the meaning of certain field codes for situations when the value of a field is not clear. In these specifications, they are called unknown values. In the past, CCS used codes 96, 97, and 98 to indicate Not Applicable, Unknown, and Not Collected, as well as allowing blanks or missing values. These codes were introduced in earlier versions of the CCS, but their use is standardized in CCS 3. These distinctions may seem subtle, but they are important for reporting clearly and unambiguously. There are four categories into which unknown values can be placed: Blanks, Not Applicable, Unknown, or Not Collected.

**Blanks (NULL)**

There are certain fields for which there is no extract value. The value would be applicable and could be known if collected; however, clinical circumstances dictate that a value cannot always be supplied. An example is social security number (SSN); some individuals may not have an SSN.

These fields can be left blank (NULL) on the initial extract; i.e., they can be left out. These fields must not be filled with spaces. In the extract file, they will be indicated by two consecutive

commas. For example, if there were three fields in a row, but the value for the second field was blank (NULL), then the extract would look like this: value1,,value3.
Note that if a blank value is to be used at the end of an extract file, there must be a comma representing that blank, shown as: ,, at the end of the file. Omitting the comma will cause the extract to ignore the value completely, meaning the blank will not be recorded.

**Not Applicable (96)**

There are certain fields where a value is nonsensical or not applicable; for example, FemaleWithDependentChildrenStatus does not make sense for a male. Also, a male cannot be pregnant. Thus, the CSB would enter a value of *not applicable*. The values of *not applicable* depend on the size of the field in which it is being used, as shown in the following table.

| | | | |
|---|---|---|---|
| Single byte field | 'A' for not applicable | Four byte field | '9996' |
| Two byte field | '96' | Five or more bytes | '99996' |
| Three byte field | '996' | | |

There are some fields in CCS 3 where the value is built into or provided by the known code, so that the 96 code does not apply. For example, an individual has to have a type of residence of some sort (data element 23), and there are codes built into the lkpResidence table to identify the possible types. Thus, if the individual is homeless or lives in a homeless shelter, then code 13 indicates that. However, the values of 97 and 98, Unknown and Not Collected, may still apply. Another example is education level (data element 21); there is a code in lkpEducation to indicate that the individual never attended school (01), so the code for *not applicable* is not needed.

**Unknown (97: Asked but not answered)**

A value may be applicable in a certain situation, but the value may not be known. Staff attempted to collect the information, but it could not be obtained. In the preceding example, if the individual were female, then she could have a dependent child, or she could be pregnant. Thus, *not applicable* would not be appropriate for this situation. However, if staff asked for this information, but the individual did not provide it or it was otherwise not available, then *unknown* would be the appropriate value. The values of *unknown* depend on the size of the field in which it is being used, as shown in the following table.

| | | | |
|---|---|---|---|
| Single byte field | 'U' for not applicable | Four byte field | '9997' |
| Two byte field | '97' | Five or more bytes | '99997' |
| Three byte field | '997' | | |

**Not Collected (98: Not asked)**

There are other situations where the most accurate description of a value indicates that it was not collected; i.e., there was no attempt to collect the information. This is different from the *unknown* code. Not collected indicates that the value would be applicable, and could be known, but its value was not obtained at the time of the extract. Note that this is different from a blank value, which is an acceptable value on some fields. However, if there is a code in the lookup table for Not Collected, then that value should be used instead of a blank.

The values of *not collected* depend on the size of the field in which it is being used:

| | | | |
|---|---|---|---|
| Single byte field | 'X' for not collected | Four byte field | '9998' |
| Two byte field | '98' | Five or more bytes | '99998' |
| Three byte field | '998' | | |

# Appendix F: FY 2020 Valid CCS 3 Services Table for Data Element 10

This table displays the ProgramAreaId, ServiceCode, core service name, and unit of service for each service that CSBs can report as a valid service in CCS 3. Services with any other combination of ProgramAreaId and ServiceCode must not be included in a CSB's CCS 3 extract submission. CSBs report services in the Service file with units of service shown in data element 10. Service files must include a ConsumerId in data element 7.

When service hours are not received by or associated directly with specific individuals or groups of individuals, then the ConsumerId field must contain a z-consumer (unidentified individual receiving services) code. A Service file with a z-consumer code is also known as an NC Service file, NC indicating the absence of an identified consumer. Service hours can be reported in a Service file with a Z-consumer code (an NC Service file) for any core service for which the unit of service is a service hour. Services with service units other than service hours must not be reported in NC Service files. Page 5 of these specifications and the core services taxonomy explain NC service hours in more detail.

Substance use disorder prevention services and Mental Health First Aid, and suicide prevention services are not included in this table because this service data is reported separately through the prevention data system planned and implemented by the Department in collaboration with the VACSB Data Management Committee. Infant and Toddler Intervention Services are not included because this service data is provided separately through iTOTS or its successor data system.

| Program Area Id | Service Code | Core Service Name | Unit of Service | Service File | NC Service File |
|---|---|---|---|---|---|
| **Emergency and Ancillary Services (Case Opening)** | | | | | |
| 400 | 100 | Emergency Services | Service Hour | ● | ● |
| 400 | 318 | Motivational Treatment Services | Service Hour | ● | ● |
| 400 | 390 | Consumer Monitoring Services | Service Hour | ● | ● |
| 400 | 720 | Assessment and Evaluation Services | Service Hour | ● | ● |
| 400 | 620 | Early Intervention Services | Service Hour | ● | ● |
| 400 | 730 | Consumer-Run Services | NA | NA | NA |
| **Services Available at Admission to a Program Area** | | | | | |
| **Inpatient Services** | | | | | |
| 100 | 250 | Acute Psychiatric Inpatient Services | Bed Day | ● | |
| 300 | 250 | Acute Substance Use Disorder Inpatient Services | Bed Day | ● | |
| 300 | 260 | Community-Based Substance Use Disorder Medical Detoxification Inpatient Services | Bed Day | ● | |
| **Outpatient Services** | | | | | |
| 100 | 310 | Outpatient Services | Service Hour | ● | ● |
| 200 | 310 | Outpatient Services | Service Hour | ● | ● |
| 300 | 310 | Outpatient Services | Service Hour | ● | ● |
| 100 | 312 | Medical Services | Service Hour | ● | ● |
| 200 | 312 | Medical Services | Service Hour | ● | ● |
| 300 | 312 | Medical Services | Service Hour | ● | ● |
| 300 | 313 | Intensive Outpatient Services | Service Hour | ● | ● |
| 300 | 335 | Medication Assisted Treatment Services | Service Hour | ● | ● |

| Program Area Id | Service Code | Core Service Name | Unit of Service | Service File | NC Service File |
|---|---|---|---|---|---|
| 100 | 350 | Assertive Community Treatment | Service Hour | ● | ● |
| **Case Management Services** | | | | | |
| 100 | 320 | Case Management Services | Service Hour | ● | ● |
| 200 | 320 | Case Management Services | Service Hour | ● | ● |
| 300 | 320 | Case Management Services | Service Hour | ● | ● |
| **Day Support (DS) Services** | | | | | |
| 100 | 410 | Day Treatment or Partial Hospitalization | DS Hours | ● | |
| 300 | 410 | Day Treatment or Partial Hospitalization | DS Hours | ● | |
| 100 | 420 | Ambulatory Crisis Stabilization Services | DS Hours | ● | |
| 200 | 420 | Ambulatory Crisis Stabilization Services | DS Hours | ● | |
| 300 | 420 | Ambulatory Crisis Stabilization Services | DS Hours | ● | |
| 100 | 425 | Rehabilitation | DS Hours | ● | |
| 200 | 425 | Habilitation | DS Hours | ● | |
| 300 | 425 | Rehabilitation | DS Hours | ● | |
| **Employment Services** | | | | | |
| 100 | 430 | Sheltered Employment | Days of Serv | ● | |
| 200 | 430 | Sheltered Employment | Days of Serv | ● | |
| 300 | 430 | Sheltered Employment | Days of Serv | ● | |
| 100 | 460 | Individual Supported Employment | Service Hour | ● | ● |
| 200 | 460 | Individual Supported Employment | Service Hour | ● | ● |
| 300 | 460 | Individual Supported Employment | Service Hour | ● | ● |
| 100 | 465 | Group Supported Employment | Days of Serv | ● | |
| 200 | 465 | Group Supported Employment | Days of Serv | ● | |
| 300 | 465 | Group Supported Employment | Days of Serv | ● | |
| **Residential Services** | | | | | |
| 100 | 501 | Highly Intensive Residential Services | Bed Day | ● | |
| 200 | 501 | Highly Intensive Residential Services | Bed Day | ● | |
| 300 | 501 | Highly Intensive Residential Services | Bed Day | ● | |
| 100 | 510 | Residential Crisis Stabilization Services | Bed Day | ● | |
| 200 | 510 | Residential Crisis Stabilization Services | Bed Day | ● | |
| 300 | 510 | Residential Crisis Stabilization Services | Bed Day | ● | |
| 100 | 521 | Intensive Residential Services | Bed Day | ● | |
| 200 | 521 | Intensive Residential Services | Bed Day | ● | |
| 300 | 521 | Intensive Residential Services | Bed Day | ● | |
| 100 | 551 | Supervised Residential Services | Bed Day | ● | |
| 200 | 551 | Supervised Residential Services | Bed Day | ● | |
| 300 | 551 | Supervised Residential Services | Bed Day | ● | |
| 100 | 581 | Supportive Residential Services | Service Hour | ● | ● |
| 200 | 581 | Supportive Residential Services | Service Hour | ● | ● |
| 300 | 581 | Supportive Residential Services | Service Hour | ● | ● |
| **Prevention Services** | | | | | |
| 100 | 610 | Mental Health Prevention Services | Service Hour | ● | ● |
| 200 | 610 | Developmental Prevention Services | Service Hour | ● | ● |

# Appendix G: Taxonomy Definitions of Outpatient and Medical Services

This appendix contains the revised Core Services Taxonomy 7.3 definition of the Outpatient Services subcategory (310), which deletes language about medical and medication services, and the definition for the new Outpatient Services subcategory of Medical Services (312). This change was implemented initially on 07-01-2017 for FY 2018.

3. **Outpatient Services** provide clinical treatment services, generally in sessions of less than three consecutive hours, to individuals and groups.

   a. ***Outpatient Services*** (310) are generally provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location, including a jail or juvenile detention center. Outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory, and other ancillary services.

   c. ***Medical Services*** (312) include the provision of psychiatric evaluations and psychiatric, medical, psychiatric nursing, and medical nursing services by licensed psychiatrists, physicians, psychiatric nurse practitioners, other nurse practitioners, and nurses and the cost of medications purchased by the CSB and provided to individuals. Medication services include prescribing and dispensing medications, medication management, and pharmacy services. Medication only visits are provided to individuals who receive only medication monitoring on a periodic (monthly or quarterly) basis from a psychiatrist, other physician, psychiatric nurse, or physician's assistant. These visits are included in medical services. The Department has identified a minimum set of information for licensing purposes that would be needed to constitute an individualized services plan (ISP) for individuals receiving only medication visits.

# Appendix H: Outcome Measure Definitions and Implementation Guidance

## Adult Suicide Risk Assessment:

Percentage of adults who are 18 years old or older, are receiving MH or SUD outpatient or case management services or MH medical services and have a new or recurrent diagnosis of major depressive disorder (MDD) who received a suicide risk assessment, completed during the visit in which the diagnosis was identified.

**Implementation Guidance**

- The date on which the MDD diagnosis is identified is the date on which it is entered in the CSB's electronic health record (EHR). Do not record an earlier date on which non-CSB staff may have made a diagnosis as the start date. The start date for the diagnosis is the date on which it was entered in the EHR. For an episode to be considered recurrent, there must be an interval of at least two months between separate episodes in which criteria are not met for a major depressive episode.
- MDD is identified with any of the codes in F32 (single episode) or F33 (recurrent episodes) in the ICD-10.
- The *Columbia Suicide Severity Rating Scale™*, Screener Version - Recent (six questions) is used. There is no assessment score; only completion of the assessment is reported, and CSBs report an assessment value of 00 None.
- The CCS 3 operational definition for this measure includes the following elements.
  - The individual is at least 18 years of age when the MDD diagnosis is made.
  - The adult must receive a MH (program area code 100) outpatient (core service code 310), medical (code 312), or case management (code 320) service; a SUD (program area code 300) outpatient (core service code 310), medical (code 312), intensive outpatient (code 313), or case management (code 320) service; or an ancillary (program area code 400) assessment and evaluation (core service code 720) service if the assessment is performed here rather than in outpatient or case management services. CSBs can aggregate multiple service units of each of these types of services provided on the same day, but CSBs must send a separate service record for each day on which each of these types of services were provided in the Service.txt file in its monthly CCS 3 extract. Alternatively, CSBs can send a separate service record for each service unit provided in a day in the Service.txt file in its monthly CCS 3 extract. See the ***Date Provided*** section on page 5 for additional guidance.
  - During the service contact when the MDD diagnosis is made, the adult receives the diagnosis, it is recorded in the EHR, and the CSB includes the F32 or F33 diagnosis code in the diagnosis record with the same date as the from date in the service record. The diagnosis start date in the diagnosis record identifies when the diagnosis was made and the same date is entered in the outcomes record included in the Outcomes.txt file submitted in the monthly CCS 3 extract. CSBs must include a start date for each diagnosis record reported in the Diagnosis.txt file in its monthly CCS 3 extract.
- Training on the use of the Columbia Scale is available from the Columbia Lighthouse project at http://cssrs.columbia.edu/trainig/training-options/.
- This outcome measure must be implemented on July 1, 2017. CSBs should implement it for all new adults beginning on that date and for all adults currently receiving MH or SUD

outpatient or MH or SUD case management services, MH medical services, or assessment and evaluation services whenever a MDD diagnosis is made.

[Reference: NFQ or CQM 0104; CMS ID 161; NQS Domain: Clinical Process/Effectiveness]

1. **Child Suicide Risk Assessment:** Percentage of children who are 7 through 17 years old, are receiving MH or SUD outpatient or case management services or MH medical services, and have a new or recurrent diagnosis of major depressive disorder (MDD) who received a suicide risk assessment completed during the visit in which the diagnosis was identified.

**Implementation Guidance**

- The date on which the MDD diagnosis is identified is the date on which it is entered in the CSB's electronic health record (EHR). Do not record an earlier date on which non-CSB staff may have made a diagnosis as the start date. The start date for the diagnosis is the date on which it was entered in the EHR. For an episode to be considered recurrent, there must be an interval of at least two months between separate episodes in which criteria are not met for a major depressive episode.
- MDD is identified with any of the codes in F32 (single episode) or F33 (recurrent episodes) in the ICD-10.
- The *Columbia Suicide Severity Rating Scale* ™, Screener Version - Recent (six questions) is used. There is no assessment score; only completion of the assessment is reported, and CSBs report an assessment value of 00 None.
- The CCS 3 operational definition for this measure includes the following elements.
  - The individual is at least seven years old and less than 18 years of age when the MDD diagnosis is made.
  - The child must receive a MH (program area code 100) outpatient (core service code 310), medical (code 312), or case management (code 320) service; a SUD (program area code 300) outpatient (core service code 310), medical (code 312), intensive outpatient (code 313), or case management (code 320) service; or an ancillary (program area code 400) assessment and evaluation (core service code 720) service if the assessment is performed here rather than in outpatient or case management services. CSBs can aggregate multiple service units of each of these types of services provided on the same day, but CSBs must send a separate service record for each day on which each of these types of services were provided in the Service.txt file in its monthly CCS 3 extract. Alternatively CSBs can send a separate service record for each service unit provided in a day in the Service.txt file in its monthly CCS 3 extract. See the ***Date Provided*** section on page 5 for additional guidance.
  - During the service contact when the MDD diagnosis is made, the child receives the diagnosis, it is recorded in the EHR, and the CSB includes the F32 or F33 diagnosis code in the diagnosis record with the same date as the from date in the service record. The diagnosis start date in the diagnosis record identifies when the diagnosis was made and the same date is entered in the outcomes record included in the Outcomes.txt file submitted in the monthly CCS 3 extract. CSBs must include a start date for each diagnosis record reported in the Diagnosis.txt file in its monthly CCS 3 extract.
- Training on the use of the Columbia Scale is available from the Columbia Lighthouse project at http://cssrs.columbia.edu/trainig/training-options/.

- This outcome measure must be implemented on July 1, 2017. CSBs should ensure that it is implemented for all new children beginning on that date and for all children currently receiving MH or SUD outpatient or MH or SUD case management services, MH medical services, or assessment and evaluation services whenever a MDD diagnosis is made.

[Reference: NFQ or CQM 1365; CMS ID 177; NQS Domain: Patient Safety]

2. **Complete Physical Examination:** Percentage of adults who are 18 years old or older, are identified as having a serious mental illness (SMI), and are receiving MH case management services who received a complete physical examination in the last 12 months.

**Implementation Guidance**

- The date of the complete physical examination reported in data element 97 of CCS 3 will be used for this measure. This measure is defined below.

  **Date of Last Complete Physical Examination:** The date on which an individual received his or her last regularly scheduled complete wellness and preventative physical examination by a medical doctor or nurse practitioner. This is not a date on which the individual was seen only in response to an illness, medical condition, or injury. This must be collected and reported by the case manager whenever the date changes for individuals of any age receiving Medicaid Developmental Disability waiver services; and for adults with serious mental illness receiving mental health case management services. If the exact date is not available or known, an estimated complete date (MM/DD/YYYY) is acceptable.

- This measure uses existing CCS 3 data from the Consumer.txt file; therefore, it will not be reported in the Outcomes.txt file.
- The CCS 3 operational definition for this measure includes the following elements.
  - The individual is at least 18 years of age and has a SMI (CCS 3 data element 13.a).
  - The adults must receive a MH (program area code 100) case management (core service code 320) service. CSBs can aggregate multiple service units of case management services provided on the same day, but CSBs must send a separate service record for each day on which case management services were provided in the Service.txt file in its monthly CCS 3 extract. Alternatively, CSBs can send a separate service record for each case management service unit provided in a day in the Service.txt file in its monthly CCS 3 extract. See the ***Date Provided*** section on page 5 for additional guidance.

3. **Body Mass Index (BMI):** Percentage of adults who are 18 years old or older, are receiving CSB MH: medical services, had a BMI documented during the current encounter or during the previous six months, and had a BMI outside of normal parameters who have a follow-up plan documented during the encounter or during the previous six months of the current encounter. Calculate this measure for all adults receiving medical services over the six-month period.

**Implementation Guidance**

- This measure contains three rates:
  - **BMI Calculated:** Percentage of adults who are 18 years old or older and received MH ~~medical~~ services who had their BMI calculated;

- **BMI Outside Normal Range:** Percentage of adults are 18 years old or older, received MH medical services, and had their BMI calculated whose BMI was outside of the normal range (this is not reported by CSBs; it is calculated by the Department); and
- **BMI Follow-up Plan:** Percentage of adults who are 18-years old or older, received MH medical services, had their BMI calculated, and whose BMI was outside of the normal range who had a follow-up plan documented.

- MH (program area code 100) medical (core service code 312) services is a core service subcategory of outpatient services. The definition is included in Appendix G.
- The CCS 3 operational definition for this measure includes the following elements.
  - The individual is at least 18
  - The adult must receive a MH (program area code 100) medical (core service code 312) service. CSBs can aggregate multiple service units of medical services provided on the same day, but CSBs must send a separate service record for each day on which medical services were provided in the Service.txt file in its monthly CCS 3 extract. Alternatively, CSBs can send a separate service record for each medical service unit provided in a day in the Service.txt file in its monthly CCS 3 extract. See the ***Date Provided*** section on page 5 for additional guidance.
- CSBs report the initial BMI assessment in data element 103 with a value of 02 and the BMI assessment score in data element 104 with the calculated three character numeric BMI score including decimal point. The range of scores includes ≤ 18.5 underweight, 18.5 - 24.9 normal, 25.0-29.9 overweight, ≥ 30 obese, but report any score from 00.0 through 99.9.
- CSBs report the BMI follow up plan documented in data element 103 with a value of 03 and with an assessment value in data element 104 of yes (01) or not eligible (02) as defined on page 46 of the Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual. Page 45 of the manual describes documentation of the follow-up plan.
- A follow-up plan for a BMI out of normal parameters may include:
  - Documentation of education;
  - Referral, for example to a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professions, or surgeon;
  - Pharmacological interventions;
  - Dietary supplements;
  - Exercise counseling; or
  - Nutrition counseling.
- CSBs must implement this measure on July 1, 2017 for 18 years and older and begin reporting BMI calculations then as they are performed. However, given the six-month follow-up, the Department will not be able to begin analyzing the entire measure until the second half of FY 2018.

[Reference: NFQ or CQM 0421; CMS ID 069; NQS Domain: Population/Public Health]

5. **Major Depression or Dysthymia Remission at 12 Months:** Original measure 5 is deferred.

## 6. SUD Services Initiation, Engagement, and Retention: Percentage of adults and children who are 13 years old or older with a new episode of SUD services as a result of a new SUD diagnosis who received the following. This measure contains three rates:

- **Initiation of SUD Services:** Percentage of these adults and children who initiated any SUD services within 14 days of the new SUD diagnosis;
- **Engagement in SUD Services:** Percentage of these adults and children initiated any SUD services within 14 days of the new SUD diagnosis who received two or more additional SUD services within 30 days of the ~~initiation visit~~ first service; and
- **Retention in SUD Services:** Percentage of these adults and children who initiated any SUD services within 14 days of the new SUD diagnosis and received two or more additional SUD services within 30 days of the first service who received at least two SUD services every 30 days for 90 days following initiation of treatment with the first service.

**Implementation Guidance**

- The measure tracks initiation, engagement, and retention of individuals in SUD services over a 150-day period. It identifies individuals in the month that begins 150 days before the end of the measurement month who have open SUD TypeOfCare (TOC) records and who received a new SUD diagnosis in that month. It then tracks this cohort of individuals over the following 120 days to identify those individuals who initiated any SUD services, were engaged in those services, and were retained in them.
- This measure uses existing CCS 3 data from the Consumer.txt, Service.txt, and Type of Care.txt files; therefore, it will not be reported in the Outcomes.txt file.
- A new episode of SUD services means admission to the SUD services program area.
- The CCS 3 operational definition for this measure includes the following elements.
  - The individual is at least 13 years of age when the SUD diagnosis is made.
  - The SUD diagnosis is identified within the range of F10 - F19 codes in the ICD-10. CSBs must include a start date for each diagnosis record in the Diagnosis.txt file in its monthly CCS 3 extract.
  - The individual must have an open ~~(~~TOC~~)~~ record for the SUD services program area (program area code 300) with a through date that is ≥ the start date (150 days prior to the last day of the measurement month) or is null and a from date that is ≤ the last day of the measurement month.
  - The individual must receive a valid SUD service: a local inpatient (core service codes 250 or 260), outpatient (codes 310, 312, 313, or 335), case management (code 320), day support (codes 410, 420, or 425), employment (codes 430, 460, or 465), or residential (codes 501, 510, 521, 551, or 581) service

    CSBs can aggregate multiple service units of each of type of service in Table 2 on page 7 for which reported service units are provided "on that date" on the same day, but CSBs must send a separate service record for each day on which each of these types of services were provided in its monthly CCS 3 extract. Alternatively, CSBs can send a separate service record for each service unit provided in a day in the Service.txt file in its monthly CCS 3 extract. See the ***Date Provided*** section on page 5 for additional guidance.

CSBs can aggregate multiple service units of each of type of service in Table 2 on page 7 for which reported service units are provided "over that period of time" for the reporting month in its monthly CCS 3 extract. However, it would be preferable to aggregate these service units for no more than one week; this would enable the second and third rates above to be calculated more precisely.

- To calculate the first rate, identify individuals with open SUD TOC records with a service record for a valid SUD service with a service record from date between the diagnosis start date and the diagnosis start date plus 14 days.
- To calculate the second rate~~,~~ for the individuals identified in the first rate, identify those who received two or more additional valid SUD services within 30 days of the service from date identified in the first rate.
- To calculate the third rate~~,~~ for individuals identified in the first rate, identify those who received at least two SUD services every 30 days for the 90 days following the service from date identified in the first rate.

[Reference: NFQ or CQM 0004; CMS ID 137; NQS Domain: Clinical Process/Effectiveness]

This measure uses the following existing CCS 3 data elements.

| Element | Field Name | Purpose |
|---|---|---|
| 2 | Agency Code | Identifies the CSB (*e.g.*, 049, 031) |
| 3 | Program Area Id | Identifies the SUD program area |
| 5 | Service Code | Identifies SUD local inpatient, outpatient, case management, day support, employment, or residential core service categories or subcategories |
| 7 | Consumer Id | Identifies an individual receiving service(s) |
| 10 | Units | Identifies SUD service units received |
| 16 | Date of Birth | Produces the age of the individual (13 and older) |
| 48 | Service From Date | Identifies the date of service for the 14-day, 30-day, and ~~three month~~ 90-day intervals |
| 61 | Type of Care From Date | Identifies ~~date of admission to the SUD program area~~ individuals with open SUD TypeOfCare records |
| 60 | Type of Care Through Date | Identifies individuals with open SUD TypeOfCare records |
| 93 | Diagnosis | The current ICD-10 SUD diagnosis of the individual |
| 94 | Diagnosis Start Date | The date the SUD diagnosis started |

# Appendix I: CCS 3 User Acceptance Testing (UAT) Process

This UAT Process is contained in Appendix D of the FY 2019 and FY 2020 CSB Administrative Requirements, which is incorporated into the FY 2019 and FY 2020 Community Services Performance Contract. The Process is included in these extract specifications for ease of reference. UAT measures the quality and usability of an application. Several factors make UAT necessary for any software development or modification project, especially for complex applications like CCS 3 or the Waiver Management System (WaMS) that interface with many IT vendor-supplied data files and are used by many different end users in different ways.

1. UAT reduces the cost of developing the application. Fixing issues before the application is released is always less expensive in terms of costs and time.
2. Ensuring the application works as expected. By the time an application has reached the UAT process, the code should work as required. Unpredictability is one of the least desirable outcomes of using any application.

In the UAT process, end users test the business functionality of the application to determine if it can support day-to-day business practices and user scenarios and to ensure the application is correct and sufficient for business usage. The CSBs and Department will use the following UAT process for major new releases of CCS 3, WaMS, or other applications that involve the addition of new data elements or reporting requirements or other functions that would require significant work by CSB IT staff and vendors. All days in the timeframe are calendar days. Major changes in complex systems such as CCS or WaMS shall occur only once per year at the start of the fiscal year and in accordance with the testing process below. Critical and unexpected changes in WaMS may occur outside of this annual process, but the Department will use the UAT process to implement them.

| **Department and CSB User Acceptance Testing Process** | |
|---|---|
| **Time Frame** | **Action** |
| D Day | Date data must be received by the Department (e.g., 8/31 for CCS 3 monthly submissions and 7/1 for WaMS). |
| D - 15 | The Department issues the final version of the new release to CSBs for their use. |
| D - 20 | UAT is completed and application release is completed. |
| D - 35 | UAT CSBs receive the beta version of the new release and UAT begins. |
| D - 50 | CSBs begin collecting new data elements that will be in the new release. Not all releases will involve new data elements, so for some releases, this date would not be applicable. |
| D - 140 | The Department issues the final revised specifications that will apply to the new release. The revised specifications will be accompanied by agreed upon requirements specifications outlining all of the other changes in the new release. CSBs use the revised specifications to modify internal business practices and work with their IT vendors to modify their EHRs and extracts. |
| Unknown | The time prior to D-150 in which the Department and CSBs develop and negotiate the proposed application changes. The time needed for this step is unknown and will vary for each new release depending on the content of the release. |

Shorter processes that modify this UAT process will be used for minor releases of CCS 3 or other applications that involve small modifications of the application and do not involve collecting new data elements. For example, bug fixes or correcting vendor or CSB names or adding values in existing look up tables may start at D-35.

**THIS PAGE LEFT INTENTIONALLY BLANK**

# Appendix J: Look up table for Referral Destination

| | | | |
|---|---|---|---|
| | **Referral Destination - for lkpreferraldestination table:** The person, agency, or organization the CSB made a referred for the individual for evaluation, treatment and/or other services (i.e. refers to external CSB partners) ** with exception of primary care services. This is not a fatal error* | Text | 2 |

Children/youth: (BH, SUD, DD):

01 School System or Educational Authority

02 Part C Provider *(NOTE: 29 are CB operated & 11 external partner programs)*

03 Psychiatric Residential Treatment Facility (PRTF) (i.e., *Alice C. Tyler Village, Barry Robinson Center, Bridges Treatment Center, Commonwealth Center for Children and Adolescents, Cumberland Hospital, FairWinds – Horseshoe, Grafton Integrated Health, Hallmark Youthcare- Richmond, Harbor Point Center for BH, Hughes Center, Jackson Field BH, Kempsville Center for BH, Liberty Point BH, North Spring BH, Newport News BH, Phoenix House Counseling, Phoenix House Program, Popular Springs Hospital, Riverside BH, Timber Ridge School, UMFS of VA-Centreville, UMFS – Richmond, Youth for Tomorrow)*

04 Family Assessment and Planning Team/CSA office

BH:

05 Other Behavioral Health Provider, including Health Dept.

06 School System or Educational Authority

07 Private MH Outpatient Practitioner

08 State Operated Hospital*

ALL: Any Ages

09 Developmental Disabilities (DD)Services Care Provider (Waiver)

10 Intermediate Care Facilities for Intellectual Disabilities (ICF/IID) – *includes SEVTC, CVTC*

11 Private Hospital

12 Other Virginia CSB/BHA

13 Department for Aging and Rehabilitative Services(DARS)

14 Department of Social Services – *for ALF or referral for NF assessment*

15 State Probation and Parole, Court system/criminal justice system

16 Specialty Provider/Clinician External (i.e., neurologist, neurobehavioral psychologist, rheumatologist, dentist, PT, OT, SLP, etc.) not associated with the CSB

17 Residential Substance Abuse Treatment Facility

18 Nursing Facility (*Includes Hiram Davis)*

Veterans/Dependent Family as applicable:

19 Federal Veterans Health Administration (VHHA) *Federal Veterans Health Administration (VHA) facilities including Veterans Affairs (VA) Medical Centers (Ex. Hunter Holmes McGuire VA Medical Center), Community-Based Outpatient Clinics (Ex: Chesapeake Community-Based Outpatient Clinic), Vet Centers (Ex: Richmond Vet Center), Community Living Centers (place where nursing home level of care, skilled nursing, and medical care are available), and/or Domiciliary (homeless services) programs.*

20 Virginia Department of Veterans Services (DVS) *Includes all DVS programs and services (including but not limited to Virginia Veteran and Family Support program, education and benefits assistance etc.)*

21 Military Treatment Facility (MTF) *Includes military health care facilities and programs that provide health care and/or behavioral health services to military service members and/or their dependents. Includes military hospitals and clinics found on military bases/posts or in Federal Government contract facilities (Ex: Naval Medical Center Portsmouth and Kenner Army Health Clinic on Fort Lee).*

*State Operated Hospital: includes Central, Western and Eastern State Hospitals; Northern, Southern, Southwestern Virginia Mental Health Institutes; Va. Center for Behavioral Rehabilitation, Piedmont Geriatric Center and Catawba Hospital

**Note: 96, 97, 98 are not valid codes for this data element.**

**THIS PAGE LEFT INTENTIONALLY BLANK**